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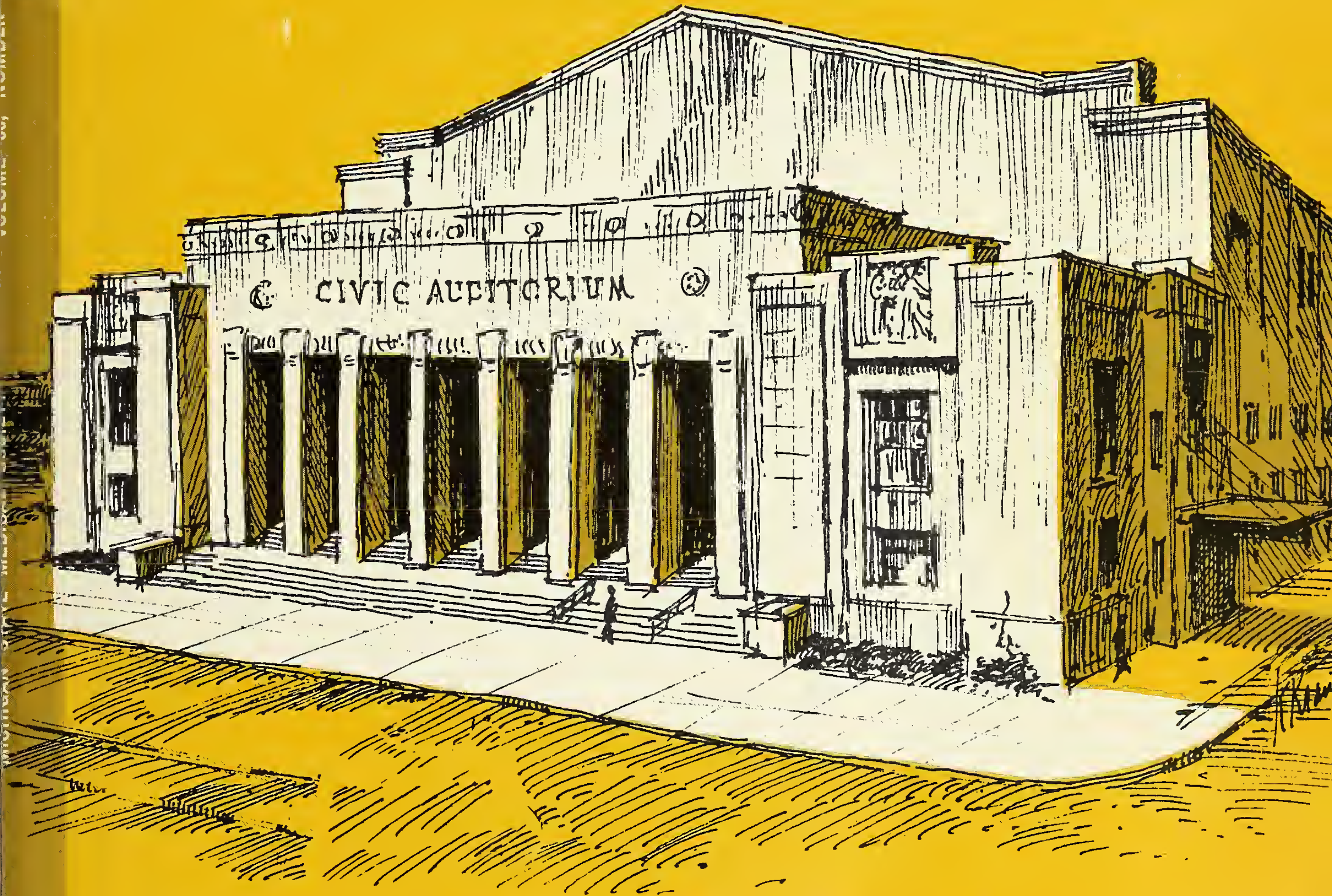

Let's All Participate September 27-28-29 In 1967 MSMS Annual Session in Grand Rapids

Turn quickly to the blue section of this July issue of Michigan Medicine for the Annual Scientific Session Program and special articles about the many highlights. Save the pages for handy reference.

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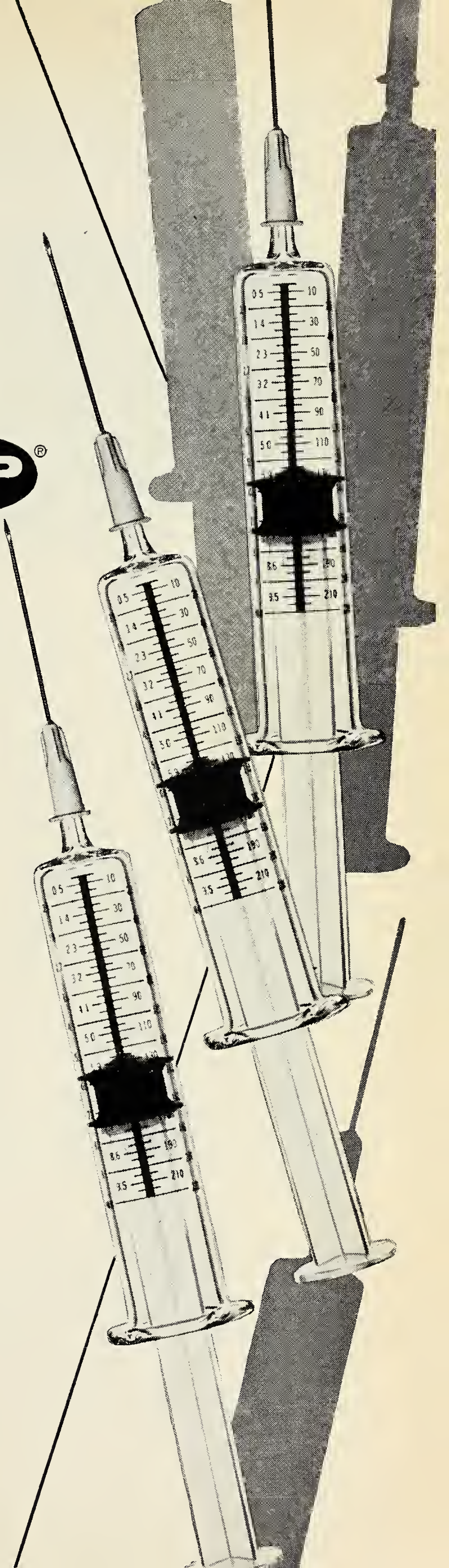

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MICHIGAN MEDICINE

SPECIAL SECTION

851 16-page Special Section about 1967 MSMS Annual Session

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Volume 66, Number 13

The original ink drawing of the Grand Rapids Civic Auditorium — location for the MSMS House of Delegates and Annual Scientific Session — was sketched for the "Michigan Medicine" cover by Kenneth Krantz. Mr. Krantz, 34-year-old graduate architect, operates studios at Suttons Bay, Traverse City, and Leland. See Annual Session Program, Pages 851-866.

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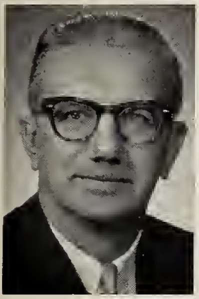

president's message

YOU ARE INVITED

Please accept my personal invitation to attend the 102nd Annual Session of the Michigan State Medical Society in Grand Rapids, September 26th through 29th, 1967. The preliminary announcement of the meeting appears elsewhere in this issue of *Michigan Medicine* and includes topics of interest to every physician, be he generalist or specialist.

You will have the opportunity to hear and see 72 outstanding speakers (28 of whom are from other states), scientific exhibits and technical exhibits. The format of the meeting will include a total of 30 symposia, seminars, panels, round-tables, and other discussion groups which will permit maximum participation of members of the audiences, thus affording answers to individual problems in all types of medical practice.

On September 24th, 25th and 26th the meetings of the House of Delegates promise lively discussions of subjects which should be of interest to all physicians. There will also be meetings of specialty and ancillary medical and health groups as well as Alumni gatherings.

The rapid growth of medical knowledge in recent years makes it unsafe for any practitioner to rely on what he learned as a student, intern, or resident or to consider his own resources as adequate for optimal patient care. The widening gap between available medical knowledge and existing medical care, the increasing demand for medical services, and the increasing patient load per physician are major challenges for all M.D.'s to become more productive.

Basic to the resolution of this gap between available medical knowledge and day-to-day practice is the rededication of physicians to individual responsibility in providing themselves with the knowledge necessary to treat their patients with the best that medicine can provide.

Your attendance at this meeting will help you meet these challenges with the least expenditure of time, effort and money; yet affording you an opportunity to renew acquaintances and confer with your colleages throughout the state.

I sincerely believe the 102nd Annual Session of MSMS will be one of the most outstanding meetings in our long history. You'll find the Annual Session Program on Pages 851-866. Save it.

Hope to see you in Grand Rapids September 24th through 29th.

C. Allen Payne MD

Gerber Research

"Tomorrow in Today's Hands"

The evening in 1927 when Dan Gerber attempted to mash peas for his infant daughter's dinner, he started a series of events that gave birth to the baby food business and the Gerber commitment to the commercial production of the best foods possible for infants.

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The first Gerber baby foods were marketed in 1928. By 1943, the company was directing all of its attention to baby foods. Today the slogan: "Babies are our business...our only business!"® identifies Gerber throughout the world and millions of mothers know and trust the more than 130 specialized Gerber baby foods. As the company has grown, it has sought the advice and consultation of pediatricians, nutritionists, home economists and mothers.

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But we live in a world of change, accelerated by new developments in science. At Gerber, we have found it necessary and stimulating to keep abreast of scientific change and to participate in the investigation of that area of science which influences human growth and development. Because of such investigation, it is becoming increasingly clear that nutrition plays an important role in biological and physiological development.

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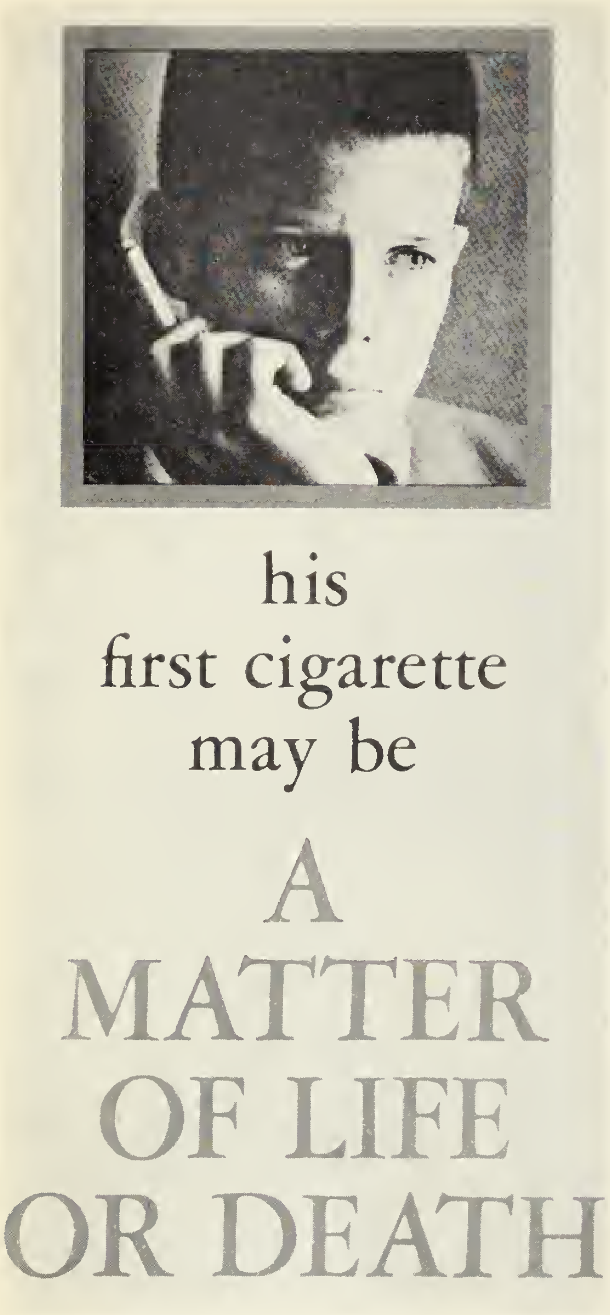

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may be

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The brochure shown above is available from the Michigan PTA for interested young people, parents, teachers, physicians, and others. The to-the-point brochure was produced by the National Congress of Parents and Teachers and is free of charge.

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Requests for a copy of the folder should be directed to the Michigan Congress of Parents and Teachers, 1011 N. Washington, Lansing.

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Typically, the obese patient is a repeat dieter. And with each failure, the task looks more hopeless. Therefore, it is often just as important to lift the mood as to curb the appetite. Desoxyn Gradumet does just that. It gently elevates and sustains the mood. And no other product—amphetamine or non-amphetamine—is more effective in suppressing appetite.

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For patients who can't take plain amphetamine

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The Gradumet is made up of thousands of interconnecting channels, much like a sponge. These channels—filled with a drug—end at the outer surface of the tablet. When fluid comes in contact with the Gradumet, the drug in the outer ends of the channels dissolves. As the fluid makes its way up the channels, there is a continuous release of medication.

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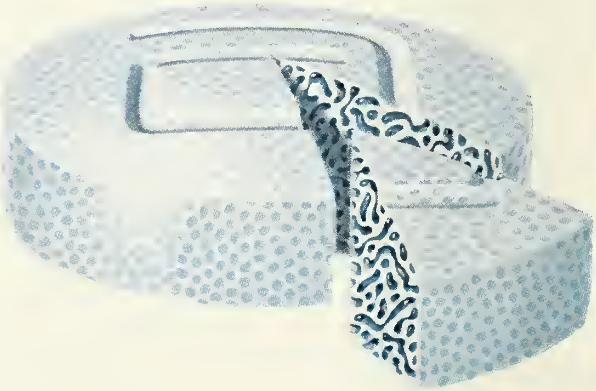


THIS IS A RELEASE YOU CAN COUNT ON

THE PROGRAM

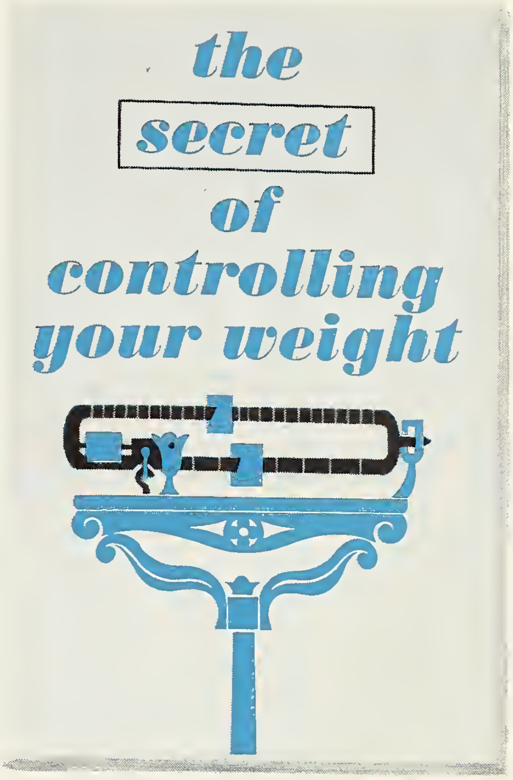
WEIGHT CONTROL BOOKLET

To help your obese patients understand why they are overweight—and what they can do about it—Abbott has a booklet called "The Secret of Controlling Your Weight." *It is available to your patients only through you.*

Here is a partial list of the topics covered:

Why you are overweight
Rewards of weight reducing
Balanced meals
Helpful hints
Hunger between meals
Snacks
Weekly weighings
Exercise
Holidays, vacations, special events
Leanness and longevity

Each topic is covered on one page in simple and easy-to-understand language. At the back of the booklet, there is a list of 160 foods showing their caloric content.



FOOD DIARY

The Food Diary is designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing everything down that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

This booklet also lists the caloric content of 160 foods.

See Brief Summary on next page.

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ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
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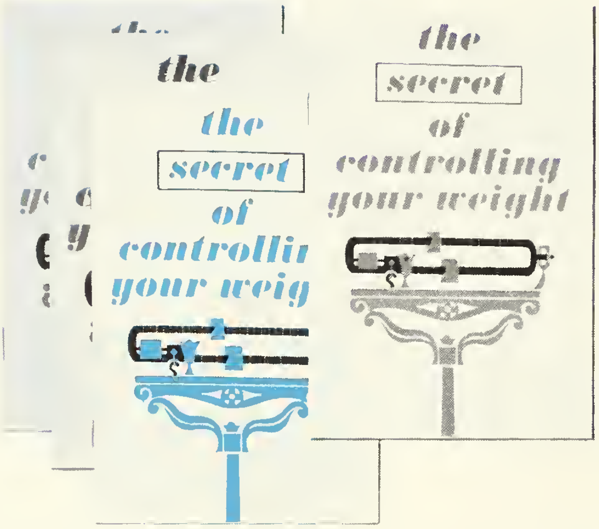

There are four weight control booklets, each with the same text, but with a different sample in the back of the booklet to meet your individual patient's needs. You have your choice of Desoxyn Gradumet in 10 mg. or 15 mg. strengths as well as Desbutal 10 Gradumet and Desbutal 15 Gradumet. The Food Diary is the same for all of the weight control booklets.

Your Abbott man will be happy to supply you with booklets. Just ask him.

CONTRAINDICATIONS: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

PRECAUTIONS, SIDE EFFECTS: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and addiction.

Amphetamine side effects such as a headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is usually transient.

701069

Gradumet—Long-release dose form, Abbott: U.S. Pat. No. 2,987,445.

HISTORY OF MSMS ADDED TO LIBRARIES

The MSMS Publication Committee has sent complimentary copies of *A Century of Service in Medicine*, the excellent history of MSMS by William J. Stapleton, M.D., to colleges, professional associations, museums, newspapers, libraries and others.

The recipients have been generous with their praise of the book published during the MSMS Centennial.

The book by MSMS Historian Stapleton is still available to interested MSMS members for $2.00, the cost of printing the handsome 56-page, hardbound book.

Following are some of the typical letters of appreciation:

"Thank you for sending the Michigan State Dental Association a copy of the centennial history book of the Michigan State Medical Society. We are most pleased to have this gift and appreciate your thoughtfulness and courtesy."

— H. Leon Snow
Executive Director

"In behalf of the Marquette County Historical Society we acknowledge and thank you for *A Century of Service in Medicine* just received. "It is a welcome addition to our research library and we are pleased to have it in our medical collection as a complement to Vols. I and II of the *Medical History of Michigan* which we find to be very useful in our work."

— Ernest H. Rankin
Executive Secretary

"Thank you very much for sending me the attractive volume titled *A Century of Service in Medicine*. This is a valuable book which we are happy to add to our library."

— R. B. Miller
Publisher
Battle Creek Enquirer and News

"Thank you for furnishing the Michigan Veterinary Medical Association with a copy of the MSMS Centennial History Book. It is an interesting addition to our library. Those who were instrumental in its publication are to be complimented on its excellence. MSMS, too, can take pride in a century of progress dedicated to the well-being of the people it has served."

— Mrs. Pat Loomis
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The Outlook for Group Practice-Payment, Direct Service Plans During the Next 20 Years

By CALDWELL B. ESSELSTYN, M.D.
DETROIT

There are times when it is difficult in the morning to foretell what will happen even in that very afternoon. Anyone who has flown knows that no matter how clear the day or high the altitude, the distance that can be seen forward, even with 20-20 vision, is limited by the horizon. A request to plot a course for 20 years ahead from ground level implies seeing not only as far as the horizon, but well over and beyond. Acceptance to undertake this exercise is with an acute awareness of human limitations and without the benefit of "over-the-horizon radar." With this understanding and with the spirit of assurance of the French surgeon whose guiding slogan read, "I may be wrong, but never in doubt," I will outline the next 20 years of group practice-prepayment, direct service plans as seen by me at the close of 1966.

Because these plans cannot function in a vacuum, it is important first to conjecture the complexion of the medical world during the future years which we will be exploring.

MEDICINE IS NOW in the most rapidly changing order in the history of our country. The increasing effectiveness of medical care has made it more and more appreciated and desired. During the time in which the chances of recovery were about equal, whether one was attended by a physician or not, there was little clamor about the necessity of making medical care available to all. We are reaching a point at which most people feel that access to high quality medical care is a right to which every American is entitled. The more effective medical care becomes, the more society demands it be made available to all. This, plus the fact that the amount of money being spent in our country for this care is representing a larger percentage of the Gross National Product each year, has stimulated the consumer to become more and more interested in the health field and to demand a place at the planning table, a place which, in the past, either he was not interested in assuming or he was not allowed to occupy. In the years ahead his influence at the planning table will be felt more and more. In the consumer's eyes, medical care is becoming much too important to be left solely to the providers.

During the transitional period in which the effectiveness of medical care has been increasing, a major thrust has been directed towards making available greater guantities of care. As the consuming public has gradually become more sophisticated, and the mysticism which formerly surrounded the practice of the art of medicine continues to be disspelled by mass media, greater interest is being directed toward the quality of care. In the years ahead the public will become more knowledgeable, more critical, and better able to judge not just the extent to which care is available, but the caliber of care as well.

Rising costs of medical care, as we have noted, have attracted individual consumers' attention and concern. This has also been true of the growing and increasingly influential third party. Electronic data processing has made possible more refined analyses of accumulated data, and a step towards uniform accounting is being taken through identical programming. Cost profiles have been developed and wide variables noted which occur not only from region to region, but even within particular areas and between particular physicians. These variables are generating a growing curiosity. In the years ahead the costs of medical care will be subject to even more data processing and public scrutiny. This, of necessity, will involve a closer

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Doctor Esselstyn is the Executive Director of the Community Health Association, Detroit.

EDITOR'S NOTE

The MSMS Committee on Medical Socio-Economics has adopted a unique approach to help physicians plan and prepare for the future.

The Committee has arranged to have experts prepare position papers dealing with the socio-economic forces that will bear on the future of private medical practice.

All position papers are the individual thoughts and opinions of the authors and are their predictions of the future impact of socio-economic movements in such areas as insurance, closed panel practice, labor, government, medical facilities, and consumer attitudes. In no way are these position papers to be construed or interpreted as the official policy of the Michigan State Medical Society. Rather, they are to encourage discussion so as to contribute to MSMS long-range planning.

Your reactions are welcomed by the Editor and the Committee.

review of the performance of the practice of medicine. Physicians will be held more accountable and their methods of practice given more visibility.

AMONG OTHER FACTORS dealing with cost, the consumer has learned that the capricious building of medical facilities, which has been traditional, has frequently resulted in duplication of facilities with resultant, added financial burdens to the community. The same may be said of services. Within the next 20 years licensing and franchising by regional planning councils, not only of hospitals, but of all medical facilities and services, will become generally accepted. These councils, with a membership composition of not more than 50 percent of providers of care, will be given the authority necessary to control the distribution of facilities and services.

Among other factors which must be considered in forecasting the future is medical manpower. Without going into the problem deeply and with an awareness that 14 new medical schools are now scheduled to be built within the next five years and many existing schools are enlarging, there will still remain the necessity to increase the shadow cast by the highly skilled professional such as physicians, dentists, nurses, and social workers. This will demand a more efficient organization of the distribution of care and the integration of paramedical and non-technical personnel to a degree not realized today. Highly skilled professionals will perform fewer and fewer tasks in medical care that can be carried out equally well by lesser-trained persons.

The people of the United States are determined to eliminate gradually the status of medical indigency. No longer will the wealthiest country in the world continue to depend more on charity medicine than do other industrial nations. The next 20 years will see a change in the approach to this problem. To date, for practical reasons, tax-supported medical care has been made available on a categorical basis — one related to disease, another related to occupation or economic status.

Thus, on the one hand, we find the government taking the responsibility of paying for, or directly providing, medical care to the indigent, migratory workers, American Indians, veterans, members of the Armed Forces and their dependents, Merchant Marine, Congress, the Cabinet, the President, and now those over 65. For years the government has also assumed responsibility for care of the tuberculous, the mentally ill, the blind, those with venereal disease, leprosy, drug addiction as well as crippled and disabled children.

This categorical approach has been followed because it has proven to be the most effective method of mobilizing funds. However, among the disadvantages of this approach, on the one hand, is the mundane problem of duplication and reduplication of administrative costs and, on the other, such factors as: the need for the continuation of eligibility tests, the stratifying of sources of payment resulting in the stratifying of the quality of care, and frequently disastrous breaks in continuity and the fragmentation of the individual. In keeping with our dedication to democracy, which can be thought of as our way of getting ahead without leaving anyone behind, the next 20 years will see a modification of this outmoded and extravagant approach to the problem as categories are coalesced. Universal access to medical care will become more of a reality. Funding will be from a

Says universal access to medical care more of reality

combination of sources — private, Social Security, and general tax funds. Payment for the services of the growing medical care team, which will be needed, will not be through individual billings by each provider to each patient, but by a single, flat fee covering total health maintenance.

PERHAPS THE MOST significant change which will influence the pattern of medical care in the next two decades, however, will be the implementation of the present-day concept of health which is the physical, mental, and social well-being of the individual. This, in itself, implies the necessity of an integrated, coordinated team approach.

To summarize these thumbnail sketches of the shape of some of the transitions we can expect in the next 20 years which will have a bearing on patterns of delivery of medical services, we find:

(1) Greater consumer interest and participation at the policy level.
(2) More visibility and accountability of physician practice.
(3) Increasing authoritative regional planning.
(4) The inclusion of a variety of lesser- trained personnel in the highly-skilled medical care team.
(5) Universal access to high-quality care.
(6) Payment for total health maintenance by a flat fee.
(7) The provision and coordination of a greatly expanded spectrum of services.

The fate of group practice-prepayment programs will depend on their ability to adapt to these influences in the years ahead.

There is an old saying that it is not so much the things that people do not know that are troublesome, rather the things that people do know that are not so. Inasmuch as many people are not aware of the facts, it seems worthwhile to examine the basic philosophy of the consumer-sponsored, group practice, direct-service prepayment plans, bearing in mind that no program which is philosophically unsound can thrive in the face of the increasing scrutiny and knowledgeable criticism of society during the next 20 years.

An Overview

In describing the development of group practice-prepayment plans (hereafter referred to as GPPP), William A. MacColl, M.D., in his book *Group Practice and Prepayment of Medical Care,* published on behalf of the Group Health Association of America, noted that ". . . the organizers of the early plans were challenged to reach into an ever-widening stream and select those fundamentals that gave promise of meeting their needs . . . The goals they selected as desirable were rational, attainable, and practical . . . . Above all they were sincere. Physicians who would listen were offered an opportunity of working together with, rather than for, the consumers. Had it been otherwise, none of the planners would have recruited any staff. Their approach was a genuine commitment to the formation of a joint venture to reach their goal."

The sponsorship of these programs has come from four general sources — the cooperative movement, industry, the community, and labor.

The cooperative type is best evidenced today by the 86,000-member Group Health Cooperative of Puget Sound and the 56,000-member Group Health Association in Washington, D.C.

The fastest and largest growing of any of the programs is the industrially sponsored Kaiser Permanente organization now serving 1,300,000 in Southern California at San Diego and Los Angeles, in San Francisco and the Bay Area of Northern California, in Portland (Oregon) and Hawaii. Although originally sponsored by Kaiser-Industries, the program is independent and self-sufficient, and today, Kaiser employees represent less than 10 percent of the membership. The largest single purchaser of care in this program is, interestingly enough, government at the federal, state, and local levels.

An example among community groups is the Health Insurance Plan of Greater New York, started by Mayor LaGuardia in behalf of the city employees, which now serves approximately 700,000 members from all walks of life through 31 affiliated groups.

IN DETROIT THE Community Health Association in six years has grown to a membership of approximately 78,000. It is under the guidance of a Board of Directors who are representative of wide

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community interests, although the initial sponsorship was by the United Auto Workers.

Of the comprehensive labor groups the Teamster-sponsored Labor Health Institute in St. Louis, together with the multi-union sponsored Community Health Foundation in Cleveland, are representative. The United Mine Workers of America, one of the early pioneers in the field, presently is providing care in 50 states and the District of Columbia to a half-million beneficiaries.

At the present time the membership of these plans is growing at the rate of five to 15 percent per year and new comprehensive GPPP plans are developing in such places as Boston, New Haven, Baltimore, and Chicago.

Some of the plans such as Kaiser, Puget Sound, and Community Health Association own their own hospitals; some, such as Group Health Association in Washington, D.C. and HIP in New York, depend on Blue Cross for hospital benefits. Other plans, such as the Labor Health Institute in St. Louis, pay for hospitalization.

Many other groups operating along the same general principles provide less comprehensive but a greater variety of benefits through different arrangements. Today there are 28 community-sponsored and 147 employer-employee-sponsored, nonprofit comprehensive group practice plans, serving some four million people who have elected to receive care through these organizations.

Distinctive Features

People frequently ask how these programs differ from commercial insurance or the Blues. This is understandable because in some ways they are similar. Group health plans, the Blues, and commerical insurance all attempt to do the one thing that insurance of any sort can accomplish, namely, spread the risk. All three kinds of plans also attempt to make benefits as comprehensive as available funds will allow. All of these plans believe in people paying for their sicknesses while they are well and spreading that payment over a period of time. The experience-rating policy initiated by commerical insurance has begun to undermine the concept of community rating amongst the GPPPs, just as it has among the Blue Cross programs. Today, the group practice programs, while firmly believing in community rating, have been forced in certain instances to begin to experience-rate.

Beyond these common essentials, GPPPs have some basic philosophical differences. It is important to understand not only these differences, but the reason for these fundamental concepts.

(1) The Question of Free Choice

There is a widespread misconception about the matter of choice in GPPPs. This is illustrated by those who still refer to these plans as "closed panel." The staffs of the plans are comparable to the staffs of voluntary hospitals. A person desiring care in any hospital is limited in his choice of physicians to those on the staff of that particular hospital. The same is true of GPPPs.

Over the past several years more and more plans have been making their programs available only through a dual or multiple-choice arrangement, respecting the right of the patient not only to select his physician, but his plan as well.

Whereas the Blues and commercial insurance in most instances continue to pay any licensed physician for any service he may render to any beneficiary at any time regardless of evidence of competence, group health plans accept the responsibility of assuring the beneficiary that the physicians from whom he may choose are qualified by training and experience to perform the service required. Within the structure of these plans physicians can perform only those services, either in office or hospital, which they are deemed, by their peers, qualified to perform. In other words, the beneficiary is given an opportunity to select from physicians who have been preselected by other physicians.

Among the reasons for this policy on the part of group health plans are studies such as the one to determine the quality and extent of health services received through collective bargaining, sponsored by the Foundation on Employee Health, Medical Care, and Welfare, Inc. and conducted by the Columbia University School of Public Health and Administrative Medicine. This study showed, among other things, that in New York City 25 percent of the hospitals used were unaccredited, and one-third of all doctors consulted had no staff appointment at an accredited hospital. Yet 40 percent of the members said their families were getting "the best that modern medicine provides."

Finds GPPP's favor group practice approach

In 1964 "A Study of the Quality of Hospital Care Received by a Sample of Teamster Family Members in New York City" was published — again by the Columbia University School of Public Health and Administrative Medicine. This study, a review of 930 inpatient admissions to 98 different hospitals within New York City, showed that 43 percent of the cases received "less than optimal care" in the judgment of reviewing clinicians. Among the lower specialty ratings were medicine, in which only 31 percent received optimal care, general surgery, in which 57 percent received optimal care (13 percent unnecessary in the eyes of the reviewing clinicians), and pediatrics, in which 43 percent received optimal care.

Owing to studies such as these, the sophisticated consumer more and more is regarding "unlimited free choice" as an obligation imposed on an unenlightened patient to choose from an unlabeled product.

(2) Group Practice

Group health plans believe that the best interests of the patient are served when physicians are organized in group practice, where there is an integration of the specialization of medicine. Here physicians with common philosophies, but separate skills, can pool their skills for the benefit of patients and work in a cooperative, rather than competitive setting. Here physicians and the rest of the growing medical team can be organized so as to be mutually responsible both to their patients and to each other.

(3) Method of Remuneration

This discussion is presented with a full realization that there are two sides to this still-unresolved and controversial issue. The temptation of over-utilization under fee for service can be balanced against under-utilization of medical services when payment is by salary. In each instance it depends on the physician's integrity, for which there can be no substitute. For years physicians have been selling services to patients who have been unable to judge the quality or necessity of such services. Consumer members, however, take comfort in the belief that under-utilization is much more apparent to the unsophisticated consumer than over-utilization.

Group health plans do not feel that the best interests of the patient, in particular, or health, in general, are served when physicians are remunerated on the traditional fee-for-service or piecework basis. The principle of piecework was invented as an incentive to encourage the production of more pieces. Over the years it has been found to be effective not only in certain industries, but in medical care as well. In medical care many studies have shown the effect has been inflationary. For years consumers have complained. At the turn of the Century, George Bernard Shaw commented in the preface to *The Doctors Dilemma*:

> It is not the fault of our doctors that the medical service of the community, as at present provided for, is a murderous absurdity. That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toenail receives a few shillings: he who cuts your inside out receives hundreds of guineas.

In 1955 Doctor Odin Anderson reported the results of a national survey conducted in 1953. In his book *Family Medical Costs and Insurance,* he reported utilization of surgical services by those covered by insurance and those without. "The appendectomy rate for insured persons in the age group 6 to 54 was 11 per 1,000; for those without insurance 5; the hospitalized tonsillectomy rate for those under 17 years of age was 30 per 1,000; for those without insurance 9."

Doctor Warren Draper, Executive Medical Officer of the United Mine Workers of America, reported that in one carefully studied area, when teams of salaried physicians replaced solo practitioners who had been remunerated on a fee-for-service basis, the rate of appendectomies for UMWA beneficiaries declined 59.2 percent.

In September 1960 the *Special Study of the Medical Care Program for Steelworkers and Their Families* became available. This Study of a million and one-quarter people showed that the 38,879 who elected to obtain their health care through a GPPP (Kaiser), where group practice doctors were remunerated by a method other than a fee for service, had similar experiences. Hospital admissions declined in this instance from 135 per 1,000 beneficiaries for those under the care of solo practitioners on a fee-for-service basis to 90 per 1,000, hospital days per 1,000 per annum from 1,032 to 570, and major surgical procedures per 1,000 from 69 to 33.

THAT THESE TRENDS continue is shown by the recent summary by George S. Perrott presented at the Joint Session of the Medical Care Section and Group Health Association of America at the Annual Meeting of the American Public

Health Association in New York City in October 1964. The summary dealt with the utilization of hospitals and services under the Federal Employees Health Benefits Program covering some 6¾ million employees and their dependents. This was a comparison of hospital utilization rates among persons in a multiple-choice program who could elect to be covered by Blue Cross-Blue Shield indemnity employee organizations, or GPPPs. The study showed that the hospital utilization among individuals insured in the GPPPs was 40 percent less than that in other plans; that those insured in the other plans had 2½ times the rate of tonsillectomies; twice the rate of appendectomies; and 1½ times the rate for female surgery, particularly dealing with breast and uterus.

While the method of remuneration of physicians in GPPPs varies, methods other than fee for service, such as retainer arrangements or fee for time or salary, with or without a bonus provision, are the rule. There is a strong feeling among GPPPs that physicians liberated from the yoke of fee-for-service payment can more readily make medical decisions based solely on patient needs. The income is usually generated through capitation, by which is meant the amount of money required per person to make available a given scope of benefits to an enrolled population for a given period of time.

(4) Payment for Health Maintenance

Unfortunately, the physician being graduated from school today is not health; but sickness-oriented. All too often he enters medical school interested in people — he is graduated having learned little about people, but a great deal about pathology. He is examined upon graduation from medical school, not on matters dealing with health, but rather disease. During internship and residency, emphasis and interest are still not on health or health maintenance or people, but on the diagnosis and treatment of the abnormal. Even chronic disease is given a secondary role, and the center of the stage is occupied by the sickest patient who either has the most bizarre ailment or is in need of the most extensive and complicated surgery. Specialty boards only re-emphasize the physician's obligation to concentrate his maximum effort on the diagnosis and treatment of disease. When he enters practice, therefore, it is to be expected that he is disease-oriented. He finds himself in a world geared to payment for treatment of illness, rather than health maintenance.

As long as the only way a physician can support himself and his family is to wait until somebody falls apart, it is understandable if his driving force in life is not preventive medicine. Nor is this a phenomenon only recently appreciated. As long ago as 1570 the philosopher Montaigne noted that doctors took little pleasure in the health of their friends. It accounts for the traditional acceptance by society that the success of physician reflects to a degree the misfortune of the community that he serves.

Payment to physicians under the Blues and commercial insurance is for sickness. No one who is healthy and well and symptom-free can legitimately enjoy any benefits from either commercial insurance or the Blues. This suggests that these plans should be referred to as "sickness" rather than "health" insurance.

In the group health plans, on the other hand, capitation is paid for the assumption of responsibility for total health, come what may. As a natural outcome, periodic checkups and preventive services are emphasized as physicians are given a financial interest in maintaining the health of individuals. Health education of members under professional guidance is a sequence to all this, and active, ongoing programs are to be found in the larger plans today.

Another by-product results when physicians are given a financial interest in maintaining people's health — expansion of public health, rather than being resisted for fear of encroachment, is encouraged and welcomed.

(5) Indemnity Versus Service

Indemnity insurance provides for payment of a stated amount of money for a given service, re-

DID YOU READ ARTICLE BY PROF. HALL?

The first in this series of position papers appeared in the January issue of Michigan Medicine. It was a comprehensive article about "The Future of Health Insurance Prepayment and Medicine — A View of 1985" by Charles P. Hall, Jr., Ph.D., Professor Insurance at Temple University in Philadelphia.

Others in the series will be received by the MSMS Publication Committee from Dale L. Kessler, M.D., Grand Rapids, Chairman of the MSMS Committee on Medical Socio-Economics.

gardless of the cost. It provides a measure of protection to the provider; it gives no predictability of liability to the consumer. For this reason GPPPs emphasize service benefits; the dues provide service rather than dollars. To varying degrees, plans charge registration fees of one sort or another, but otherwise the service benefit concept is strictly adhered to.

Indemnity coverage will become less popular in the years ahead, although it represents the bulk of coverage in health benefits today. To quote Jerome Pollack, Associate Dean for Medical Care Planning at Harvard Medical School, "Indemnity dealings are harming the prestige of medicine beyond the remedy of public relations. Both the profession and the public would be vastly better served if a mutually acceptable way were found to provide service benefits for the people."

(6) Consumer Participation

The organization of consumer-sponsored group health plans provides the consumer in varying degrees with a place at the planning table to which we previously referred. With a firm understanding that professional standards and the practice of medicine are solely the physicians' prerogative, many of the plans have delegates representing blocs of members who meet regularly to discuss mutual problems with their physicians and the administration and ways in which, by working together, the group health plan can be improved.

(7) Profit versus Nonprofit

Differing from commercial insurance companies, but not the Blues, the GPPPs are organized on a nonprofit basis. This does not imply that physicians and other members of the staff are not entitled to a remuneration which is reasonable, just, and competitive. It does imply, however, that no income inures to the benefit of any member of the board of directors and that all income must be applied towards the charter purposes of the program. GPPPs do not feel the best interests of the consumer are served by organizations whose driving force, of necessity, is to make money.

This summarizes in a general way some of the distinctive features which will determine, to a large extent, the future of GPPP during the next 20 years.

Interaction with Important Groups

Let us next consider whether programs based on these fundamental concepts will meet the demands of society and the profession in the years ahead.

History has shown that changes in patterns of care have traditionally originated from without, rather than from within, the profession. This suggests that the patterns of care in the ensuing years will be set not alone by the 200,000 plus or minus producers, but in conjunction with the 200,000,000 plus or minus consumers.

What then, if any, are the reactions to GPPP by four major groups: (1) physicians entering practice, (2) the consumer-at-large, (3) the organized consumer, and (4) the planners.

(1) Physicians Entering Practice

Because experience has shown that well-established solo practitioners are less likely to be interested in joining GPPPs, emphasis will be given to the physician entering practice, who will be representing the 30 to 50-year-old practitioners during the years under discussion. Hunt and Goldstein (1946) initiated a study — later revised by Pomrinse and Goldstein (1959) — which indicated a substantial growth of group practice and showed, at that time (1959), that 10.29 percent of the active practicing physicians in the United States were members of some form of group practice. Physicians entering practice join GPPP for many of the same reasons they join group practices. What are the factors which make group practice attractive to physicians and will these influences continue in the years ahead?

A. In the first place, it is the only kind of a setting in which they have ever functioned. When they were in medical school, they were within the framework of what might be thought of as a loose group, namely the faculty. During their internship and residency, a group structure was also provided. Finally, during their duty in the Armed Forces, they again worked in something of a group practice setting. So, it is the only kind of a framework with which the beginning physician is familiar.

B. Although a good deal is said about medical students being the children of wealthy families, statistics show that after a physician has finished four years of college, four years of medical school, and three to five years of training, more often than not he is married, has a family, and is in debt. The opportunity to enter practice without going further into debt to capitalize the establishment of an office is attractive. The cost of establishing an office with adequate equipment which a surgical specialist in practice five years, I feel will permit him to practice, in the manner in

Cites same reasons for physician to join GPPP as a group

which he has been trained, will become even greater in the years ahead.

C. It is well known that no matter how many years a physician may have trained within the protected walls and artificial environment of an ivory tower, there are many things still to be learned when he enters the world of practice. To be able to learn "the art" within the framework of a group of cooperative doctors, who want to see him succeed, is a privilege which he understands.

D. The necessity for ongoing continual self-renewal through post- graduate education is understood by most of the students being graduated today. It will be even more important as changes in the science of medicine accelerate in the years ahead. Whether it is for vacation, sickness, or continuing education courses, the solo practitioner cannot help but realize that when he turns they key in the door of his office, all income ceases and all expenses go on. Regular time off for whatever reason can be readily made available within the framework of a group through the rotation of physicians. The ability to have predictable free nights and weekends allows a physician to live a more normal and wholesome family life.

E. By the time a physician is trained, he has spent almost his entire effort and undivided attention learning medicine. It is unrealistic to think that the physician is well-equipped to handle the business aspects of private practice which, over the years, have and will become even more demanding. Group practice affords the opportunity for the physician to apply his full time and effort to the practice of medicine for which he has been trained, allowing the business aspects of practice to be taken care of by an administrator whose training and interests make him better qualified to assume this responsibility.

F. Physicians entering private practice frequently find business is slow, not just for months, but sometimes for years. As bitterly stated by a medical doctor from Montana in the September 19, 1966, issue of *Medical Economics,* page 41, "As that it's virtually impossible for a well-trained, completely honest man to become successful before his skills deteriorate." GPPPs do not add physicians to staffs unless caseloads justify another doctor. There is plenty to be done from the start.

G. Finally, it has been shown that whereas, within the structure of group practice, incomes may never reach the peaks of specialty solo practice, they are competitive because they begin at a higher level, they are more predictable, and they do not fall off as rapidly in the later years. This also lessens the impact of income tax (which may well be higher in the next 20 years) applied to peak-year incomes. In addition, within the nonprofit group practice setting, considerable savings can be enjoyed through fringe benefits.

There is reason to believe that these same advantages will continue for the beginning physician during the next 20 years.

(2) Consumers-at-Large

Studies have documented that the elements in prepaid group health plans which patients appreciate are:

A. The availability of practically all of the services under one roof.

B. The sense of comfort which comes from being able to select from physicians whose competence is known because they have been preselected by other doctors.

E. The ease of referral when there is no threat to the personal physician of loss of prestige or income.

D. The knowledge that necessary services are available 24 hours a day, 365 days a year, and that if the personal physician is not available, a physician member of the same team will be, a physician with a common philosophy and equal training who has ready access to the patient's record.

E. The understanding that whether the physician decides to move to another locality or not, a permanent health record will always be available.

F. The security in the assurance that the professional judgment of the physician is independent of any monetary influence.

G. The ability through the group health plans to budget owing to the predictability of virtually all costs of professional medical care, just as can be done with rent, heat, and light.

These factors would seem to be enduring.

(3) Organized Consumers

Although representing a relatively small percentage of the total number of consumers, probably the best organized, the most articulate, and one of the most knowledgeable groups concerning medical care is labor, which has given considerable thought to health problems and, through collective bargaining, has been able to generate in health and welfare funds some $70 billion. Yet, in spite of this, labor is unhappy. At a meeting of the Executive Council of the AFL-CIO in Miami in 1963, a resolution was prepared attributing this dissatisfaction to four principal causes:

A. An inability to control quality,

B. An inability to purchase comprehensive care,

C. An inability to purchase preventive care, and

D. An inability to control costs.

If we can determine how group health plans deal with these problems, perhaps we may be able to determine to what extent, at least, this segment of society will wish to be served by them in the coming years.

(A.) Group health plans do, to a measure, control quality through the selection of physicians for their competence as we have seen. I would be the last man to intimate that the mere structure of a group insures good medical practice. On the contrary, I have always maintained that there is nothing worse than one incompetent doctor unless it is a group of incompetent doctors. Unfortunately there are some unethical groups, and some of the national surveys have revealed startling abuses within these groups. May I hasten to add, however, that these have not been consumer-sponsored nonprofit groups. By and large, as the late Doctor Allan Gregg noted, "The service given a patient by group practice gains in quality by the criticism of the other members of the group whether that criticism be tacit or fully expressed . . . the fact remains that doctors sometimes do need, and usually respond well to the realization that their work is observable and observed."

In any consideration of controlling quality of care, we must consider control of ambulatory care as well as of care within the hospital. The medical profession has felt it necessary for hospitals to have a battery of watchdog committees in order to meet the minimum standards of accreditation. Thus, to protect the patient even within the confines of the hospital walls, it has been found necessary to have tissue, sterilization and abortion, chart, credential, medical audit, and utilization committees — to name a few.

The consumer is beginning to ask what committees are there to protect the interests of the patient outside of the hospital where by far the bulk of medical practice is performed. Within the GPPPs visibility and accountability of the entire practice of medicine is assured — both within and without the hospital.

(B.) What about the second point — the lack of ability to purchase comprehensive care? We have done the image of the wonderful family doctor the greatest honor when we relegate to the past, unblemished, something which was good in its time and commanded respect. But we do not honor the general practitioner by trying to bring him back, as he was, into the practice of medicine — either today or within the next 20 years. Because of the accumulating body of knowledge, if for no other reason, a single physician can no longer provide the best there is to any one patient in all the fields of medical care. The day of the specialist is here, whether we like it or not. Within this specialist group it is possible and important for patients to select a personal physician, the modern counterpart of the family doctor. GPPPs can provide coordinated comprehensive care to a degree limited only by the amount of funds available through the integration of the specialization of medicine. This fundamental ability of group practice cannot be emphasized too often.

(C) We have already alluded to preventive services. In group health plans in which prepayment covers total medical care, sickness becomes a liability, and preventive services automatically become correspondingly more important.

(D) The ability of GPPPs to control costs will be discussed later.

(4) The Planners

As Sir Geoffrey Vickers said in an article in *The Lancet* (I, mxxi), "What Sets the Goals of Public Health," "Our society is run by people who are accustomed and professionally trained to see and answer technological questions and financial questions and legal questions and administrative questions. Only very few people are accustomed and professionally trained to see and answer questions about people as people."

From time to time, national surveys have attempted to study the medical and social needs of "people as people." Their recommendations regarding group practice are pertinent to any long-range projection.

In 1927 a group of public-minded leaders representing practitioners, public health workers, educators, and industry undertook a nation-wide study under the chairmanship of Doctor Ray Lyman Wilbur, a Past President of the AMA. Five years later, after many committee reports and studies, the final volume, *Medical Care for the American People,* was published by the University of Chicago Press in 1932.

Doctor I. S. Falk summarized some of these findings at the APHA meeting held in Cleveland in 1957 and later published in the APHA *Journal of Public Health* (August, 1958, II, 48):

> 1. Medical services should be more largely furnished by groups of physicians and related practitioners, so organized as to maintain high standards of care and to retain the personal relations between patients and physicians.
>
> 2. The costs of medical care should be distributed over groups of people and over periods of time.
>
> 3. Methods of preventing disease should be more extensively and more effectively applied, as measures both of service and economy, and should be so financed as to minimize the economic deterrents to their extension.
>
> 4. The facilities and services for medical care should be coordinated by appropriate agencies on a community basis.
>
> Of particular interest to us here is an amplification of the first of the recommendations:
>
> The Committee recommends that organized groups of consumers unite in paying into a common fund agreed annual sums in weekly or monthly installments, and in arranging with organized groups of medical practitioners working as private group clinics, hospital and medical staffs or community medical centers, to furnish them and their families with virtually complete medical services. By 'organized groups of consumers' the Committee means industrial, fraternal, educational or other reasonably cohesive groups.

In 1947, a report of the New York Academy of Medicine Committee on "Medicine and the Changing Order" was published by the Commonwealth Fund.

This study noted (page 139) "group practice in principle provides various advantages not found in the prevailing form of private practice. It affords a better quality of care to patients and improved professional conditions for physicians. Most important, it is more adaptable than solo practice to comprehensive voluntary plans and so facilitates a wider extension of medical care."

And later, among recommendations (page 223), "Improvement in medical service requires effective use of hospitals with adequate facilities. Among other things, this implies development of better outpatient department clinics and the use of hospital facilities by groups of physicians to reduce the actual and relative cost of medical service. By such arrangements large items of capital investment and the failure to use in full the facilities available, now implicit in office practice of individual physicians, may be eliminated."

In 1951 the President's Commission on the Health Needs of the Nation, *Building America's Health* (II, 246), recommended that:

> 1. Groups be organized on a basis which favors high standards of practice and maximum participation, financially as well as professionally, by all member physicians.
>
> 2. Organized medical bodies review their attitudes toward group practice in a spirit of tolerance.
>
> 3. Federal loans be made to local organizations desiring to institute prepayment plans associated with group practice, for the purpose of encouraging the establishment of group practice facilities.

In 1958 The Rockefeller Brothers Fund published *The Challenge to America: Its Economic and Social Aspects.* Under item number 4, page 58, "Paying the Costs of Medical Care" is the following:

> As medical practice has become more complex and specialized, it has become apparent that cooperative efforts among practicing physicians can enhance the quality of care given. The first question is how best to achieve this. The second is how to pay for high quality medical care so as to spread costs among a large group of individuals and families, and over years of high and low health costs for each individual or family. The increasing costs of hospital and medical care lend urgency to this question.
>
> One approach, adopted effectively in some communities, is group medical practice, affiliated with a common hospital, and with essentially all costs prepaid by the subscribers through family health insurance premiums. The range of physician services covered by the fees should be comprehensive in scope. The resulting incentives tend to emphasize preventive care and early diagnostic services; and to minimize unnecessary hospitalization. We believe that this group practice prepayment approach, although by no means suited to all communities, could be advantageously adopted by more communities.

Finally, in the Report of the National Commission on Community Health Services (1966) *Health is a Community Affair,* page 63 reads:

> Group practice of medicine, as a specific way of integrating the services of physicians, has demonstrated that it can provide an effective and efficient method of furnishing comprehensive medical care of good quality. Such organization of services should be stimulated and encouraged as one of the best routes toward comprehensive personal health services with the understanding that for each patient, one physician is his personal physician. (C-3) Group practices require the services of nurses, social workers, laboratory technicians, receptionists, accountants, and other allied personnel. Therefore, the model for

provision of health care has grown from the individual, his family, his personal physician and associates, to include a number of additional persons and additional services.

It would seem that the suggestions of these planners might indicate the desirability for the further development of GPPPs in the ensuing years.

Problem Areas

It is essential to describe some of the deterrents to past, present, and future growth in relationship to individual physicians, consumers, organized medicine, the law, and financing.

(1) Physicians

A. Group practice is not every physician's choice. Nor is this any reflection on such a physician. Some of the most able and dedicated doctors in practice today are distinctly "loners." As one doctor suggested, it is "independence uber alles." In an association in which the reputation and security of a physician becomes closely related to the performance both on and off the field of other physicians on the same team, the relationship becomes intolerable to certain doctors. It becomes a little too folksy. As William Lyon Phelps once noted, "If a person can be happy at home, he can be happy anywhere."

B. Adherence to necessary regulations, intragroup medical audits, limitation to certain formularies, and countless other orderly procedures which must be maintained in any well-run group can be sources of irritation to other physicians.

C. The ability to play as a member of a team, requiring subordination of personal distinction to the good of the group, requires a degree of tolerance and flexibility not found in all.

D. It is not an overstatement to mention that in the past, members of GPPPs have not been popular with county medical societies. The resulting professional isolation has often been a factor which has caused some physicians to decide against joining a GPPP. Today, however, particularly where plans have been in existence for a second generation of physicians, the relationship with local county societies is slowly improving.

E. The limitation of consultants to group members has been a problem to some. This applies particularly to the smaller groups.

F. Although departments of community medicine are slowly being established in medical schools around the country, in a surprising number of schools students have never been exposed to the various existing patterns of care. They are graduated with no knowledge of the variety of ways from which they may select their method of practice.

G. Although for years remuneration to physicians has been meager, incomes, as we have noted previously, are becoming competitive today for a variety of reasons, particularly when enriched with fringe benefits that are available.

While these last two items will diminish in the years ahead until there are basic changes in some physician attitudes, the other deterrents to physician enrollment may well continue.

(2) Consumers

We have been alluding from time to time to the high quality of care. Just what is meant by this term? I believe it can be defined as the degree to which medical care is available, acceptable, comprehensive, continuous, and documented, as well as the extent to which adequate therapy is based on accurate diagnoses rather than symptomatology.

It has been recognized, as noted previously, that for years physicians have been selling services to those completely unable to judge the quality or necessity of these services. Consumer concern, by and large, centers around the first two criteria, namely, availability and acceptability. By far the greatest number of complaints from enrolled populations have to do with delay in obtaining elective appointments and waiting time in doctors' offices. These largely administrative problems vary substantially between groups and are subject to resolution, to some degree at least, by joint conferences between administration, physicians, and patients. Nevertheless, the problem persists.

The acceptability problem revolves largely around the much overworked phrase "doctor-patient relationship." This might be an appropriate place to attempt to define this elusive factor which has a fairly high emotional content. Much has been written by others, describing at great length the subtleties of this factor, complete with diagrams, anterior, posterior, lateral, and oblique views. After reading some of these statements, one gets the idea that some consider it to be primarily a financial relationship — others a legal transaction or contract.

Doctor R. M. Magraw, in his recent book *Ferment in Medicine,* has this to say: "Perhaps the analysis of this relationship can best begin by recognizing the complexity of the process. It is a shifting dynamic relationship or transaction and not simply the interaction of two unchanging objects in juxtaposition to one another."

I happen to think that the ingredients in a doctor-patient relationship, upon which patients' satisfaction depends, can be defined in much plainer terms. To me, satisfaction is determined by the abilty of a physician not only to command the respect and confidence of a patient and to convince a patient of a personal concern for his welfare, but also the degree to which a doctor is capable, or cares to give, not only his time or his knowledge, but himself. Needless to say, this means there are wide variations.

MUCH CRITICISM has been directed toward the impersonal treatment sometimes provided in group settings. This has nothing to do with time. Whether in solo or group practice, certain physicians can provide more personal care in five minutes than others can in an hour. Also some physicians enjoy people, and people reciprocate. If the driving force in a physician's life is an interest in people, there is nothing in a GPPP environment which will not allow this to be obvious. Unfortunately not all physicians are so imbued.

Not all plans can be all things to all people. Just as group practice is not the setting in which all physicians find the greatest satisfaction, GPPPs are not the setting within which all consumers find their greatest satisfaction. It takes two to play the game successfully. As a stable marriage depends not only on finding the right partner, but also on being the right partner, contented membership in GPPPs requires sympathetic cooperation on the part of the consumer and a willingness to live with some of the minor inconveniences and rules of conduct essential to any organized program.

Within every enrollment there will always be some people who want to change physicians — or even plans. Most plans provide periods during which shifts can be made from one plan to another. Dual choice has been a blessing in these circumstances, both to patients and plans.

(3) Organized Medicine

In any society there are those who fear change, and this has applied to the attitudes of the AMA and its constituent state and county societies. Little is to be gained in forecasting the future by delving into some of the past sanguine confrontations between organized medicine and GPPPs, except to note that bench marks have been established through a variety of legal actions. These have been summarized by Horace Hansen, for many years counsel for the Group Health Association of America, and are available through the offices of the Association. It is noteworthy, however, that since legal battles were first joined between the Group Health Cooperative of Washington, D.C., the AMA, and the District of Columbia Medical Society in 1938, until the most recent (1966) court decision, having to do with the Bellaire, Ohio, Medical Foundation, the group health plans have won every contest. As Hansen noted, "The keystone of the common law is the public interest. In all of the cases, concern for this consideration was evident."

Fortunately, statesmanship is becoming apparent on all sides. Although GPPPS are still viewed with suspicion and distrust in certain regions, the overall picture suggests that the relationship with organized medicine should not be the same deterrent to growth in the next 20 years that it has in the past.

(4) The Law

Following the report of the Committee on the Costs of Medical Care, state laws began to appear governing the chartering of medical service corporations. Without getting entangled in this legal jungle, the situation may now be summarized by saying that currently 17 states prohibit the formation of consumer-sponsored groups; 18 states are permissive; 5 states have legislation specifically mentioning approval of consumer-sponsored plans; and in the remaining states there are no health-plan codes.

The precedent set by the 1964 New Jersey Supreme Court decision in favor of Group Health Insurance of New Jersey vs. the Insurance Commissioner should serve as a basis to eliminate restrictive legislation in other jurisdictions.

Legislation which is restrictive to the development of GPPPS during the next 20 years would appear to be waning.

(5) Finances

A. Initial Capital Needs

GPPP organizations have had difficulty in the past generating finances for the acquisition or construction of the physical plant and for the working capital necessary to launch the operation. Financial backing for these purposes, as we have noted, has come from either the cooperative members themselves, industry, and/or labor. In the case of the Health Insurance Plan of Greater New York (HIP), initial financing came from a combination of Foundations.

Once started, these plans, by and large, have been self-sustaining; e.g., Kaiser now is able to attract commercial loans; HIP has paid back all of the original Foundation money and now has substantial reserves; CHA in Detroit is currently devoting approximately 10 percent of annual gross income to debt retirement and interest.

In his message to Congress in February of 1963, President Kennedy observed:

> Concern over the shortage of professional personnel and the shortage of health facilities makes clear the desirability of encouraging those efforts which seek to make the most effective use of both. Experience has demonstrated that both patients and professional personnel benefit from group practice facilities — where general practitioners and specialists are able to combine their diverse professional skills and use common facilities and personnel to furnish comprehensive medical and dental care. Group practice of medicine and dentistry promises to improve the quality of medical and dental care, while making possible significant economies for both patient and practitioner.
>
> Unfortunately, the difficulty of obtaining financing on reasonable terms to construct and equip such facilities is too often a major obstacle in their development.
>
> In order to encourage this trend, particularly in our smaller communities and under the sponsorship of cooperative or other nonprofit organizations, I recommend legislation to authorize a 5-year program of Federal mortgage insurance and loans to help finance the cost of constructing and equipping group practice medical and dental facilities.

Recently enacted P.L. 89-754, the Demonstration Cities and Metropolitan Development Act of 1966, provides in Title XI.

> It is the purpose of this title to assure the availability of credit on reasonable terms to units or organizations engaged in the group practice of medicine, optometry, or dentistry, particiularly those in smaller communities and those sponsored by cooperative or other nonprofit organizations, to assist in financing the construction and equipment of group practice facilities.

During the next 20 years this Bill will have a positive influence in the proliferation of GPPPs by solving one of the major deterrents to developing new plans.

B. Operational

We have noted previously, under our discussion of methods of remuneration of physicians, some of the economies provided by the GPPPs. It is important that the capitation method of payment be fully understood because it constitutes an economic keystone. Some economists hold that capitation is the total cost of a program divided by the number of people in the program. This is very different from the concept of capitation adhered to by the GPPPs, who recognize capitation as the amount of money required per person to make available covered services to an enrolled population for a given period of time. Implicit in the principle is a constant awareness of the need for thrift on the part of every member of the entire effort.

Capitation can be applied not only as a method of payment for medical services, but for hospitalization as well.

The effect of capitation as a method of reimbursement of hospitals has been demonstrated by Blue Cross in an interesting project in Yuma County, Colorado. The results of this study, as summarized in the *Weekly News Digest* of September 10, 1965, are as follows:

> During the first year of this experimental program, the total number of in-patient days per 1,000 Blue Cross subscribers declined by 7.5% in Yuma County, whereas it increased by 3.5% throughout the state. This decrease was almost entirely due to a reduction in length of stay: The 'average' length of stay for Yuma County Blue Cross subscribers dropped 7.2%. This figure breaks down to a 17.2% decline for those hospitalized in Yuma County hospitals and a 3.8% decline for out-of-county patients. Length of stay for all Colorado Blue Cross hospitalized patients increased 1.4% during the same period.
>
> The success of the program, based on the first year of experience, has resulted in an extension and further evaluation of the project.
>
> One question which is currently under consideration is whether it would be too difficult to administer such a program in a more metropolitan area. Admittedly, there would be a higher degree of complexity, but since most families tend to associate themselves with just one or two hospitals it would be not too difficult to chart utilization in a manner similar to that which has been done by some of the areawide planning councils.

If one gives a little thought to the dynamics of this method of reimbursement, it becomes evident that:

1. The hospital has a known and predictable

budget for a stated period;

2. The success of the administration and staff is no longer measured by the percentage of occupancy;

3. The full bed is no longer an essential asset; and

4. The empty bed is no longer a liability.

The same can be said in relation to extended care facilities.

For over two years the Community Health Association in Detroit has reimbursed Metropolitan Hospital by means of a reimbursement formula based on capitation rather than per diem, which is simply a modification of the fee-for-service principle. Today this reimbursement formula also includes in the overall capitation an allowance for care in extended care facilities as well as 60 home visits by an organized home care team (VNA). The interest and concern this method of remuneration encourages, both on the part of administration and physicians, to make the added effort necessary to be sure that a particular patient is in the most appropriate facility at the appropriate stage of his needed medical care, adds to the effectiveness of utilization review.

If the basic methods of financial operation with all the inherent delicate checks and balances can remain intact, the soundness and economies inherent in the system under which the GPPPs are now operating will be appreciated in the years ahead. To the extent that current practices are disturbed, the very lifeblood of the programs will be threatened and eventual destruction will be inevitable.

The Impact of Recently Enacted Federal Legislation

Recent legislation cannot help but influence GPPPs in the years ahead. A few pertinent bills will be mentioned.

P.L. 89-754:

We have already referred to Title XI which will make guaranteed federal mortgage loans available to GPPPs. It should also be noted that this bill provides authority for comprehensive city demonstration programs for rebuilding slums and blighted areas, including the public facilities (education, health, and social services . . .).

P.L. 89-97:

Both Titles XVIII and XIX of this bill will have far-reaching influences on medical care in general and GPPPs in particular during the next 20 years.

Because of the great importance of this bill, some details relating to the provision of certain methods of remuneration will be reviewed.

Title XVIII:

It was congress' intent to make specific provisions in this legislation to assure the future health and well-being of the GPPPs. So we find in H.R. 1, introduced by Mr. King in the House of Representatives on January 4, 1965 (Companion Bill S. 1 was introduced by Senator Anderson January 6, 1965), the following:

> That this Act, with the following table of contents, may be cited as the "Hospital Insurance, Social Security, and Public Assistance Amendments of 1965. . . .

Under "Determination of Cost of Services:"

> Such regulations may provide for determination of costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, and may provide for use of estimates of costs of particular items or services.

This clearly shows it was Congress' intent to allow payment for services covered in the original King-Anderson Bill (now covered under Part A of Title XVIII of P.L. 89-97) by a variety of methods.

It will be remembered that another layer of benefits, to be financed through a voluntary supplemental plan, was added to H.R. 1. On pages 43-44 of the report of the Senate Finance Committee of this bill, known as H.R. 6675, the following language indicates the understanding of this Committee that payment both for Parts A and B services might be by capitation.

> (c) *Method of payment under the voluntary supplementary plan*
>
> . . . The Committee bill would provide group-practice prepayment plans with the alternative of having the program pay 80 percent of the reasonable cost of the covered services they furnish (including physicians' services) rather than 80 percent of the reasonable charges. The committee believes this charge is desirable to accommodate group-practice prepayment plans. Under such plans there is usually no charge for a specific service, the physician being paid by the plan on a salary or other basis unrelated to reimbursement for a specific service. Among the bases permitted for reasonable cost determination is the calculation of costs on a per capita basis — the one which the group practice prepayment plans generally use for their members. Reasonable cost, as defined for purposes of reimbursement under the supplementary plan, would be the same as under the hospital insurance plan. . . .

There are three parts of P.L. 89-97 which are particularly pertinent and read as follows:

> *Sec. 1801.*
>
> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation

> of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Again, under *Section 1833(a)* dealing with payment of benefits under Supplementary Medical Insurance Program:

> (1) in the case of services described in section 1832 (a) (1) 80 percent of the reasonable charges for the services; except that an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b) ;

Again, in *Section 1861 (v) (1)* dealing with 'Definitions of Services, Institutions, Etc.," involved in both Part A, Hospital Insurance Benefits for the Aged, and Part B, Supplementary Medical Insurance Benefits:

> . . . Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs.

The Social Security Administration is working diligently and sympathetically with the GPPPs to solve existing problems so that under P.L. 89-97 there may be as little dislocation as possible in the usual method of operation or disturbance of the financial dynamics which have been largely responsible for the proven economies of the GPPPs, in making available a continuity of comprehensive care. Although in most vital areas the language in P.L. 89-97 is specific and favorable, in certain areas legislative changes may be necessary.

Title XIX of P.L. 89-97, which will eventually involve approximately twice the 19 million beneficiaries now covered under Title XVIII, is of corresponding importance to GPPPs. It must be remembered that this is a program administered by the states, so 50 different versions may be expected. The Casey Bill, which is the California interpretation of Title XIX, has clear and specific language accommodating the contracting for care through GPPPs. Medicaid in New York State also provides for this kind of arrangement, and already the Health Insurance Plan of Greater New York has enrolled over 20,000 Medicaid beneficiaries. Not all state Title XIX laws are as clear. There can be no question, however, that Title XIX is intended, also, to provide for the payment for services by a capitation arrangement.

I would like to quote from some recent personal correspondence with Federal Commissioner Ellen Winston:

> . . . You asked particularly about the possibility of utilizing group practice facilities through a prepayment or capitation type of payment . . . Supplement D of Handbook of Public Assistance Administration is quite clear on the subject. I call your attention to Section D-5830 of the Handbook which outlines the possibility of this type of arrangement.
>
> D-5830. *Health Insuring Organization*
>
> A health insuring arrangement is present where the contractor agrees to pay the costs of benefits provided under the contract in consideration of an amount called a premium, paid by the State agency for each eligible individual. Under this arrangement, the State agency would be obligated to pay for eligible individuals a monthly premium for each month for which coverage of the medical care and services provided for in the contract is to be made available, whether or not such individuals needed such care and services. Such payment might be made in advance of the coverage period or shortly thereafter. Also, the State agency would not pay for any loss incurred by the contractor from claims exceeding premiums paid or from increases in administrative costs of the contractor during the covered period. . .

Doctor Winston goes on to say, "I will make a special note to mention the possibility in the meeting we are having with all State public welfare directors on October 24-26, 1966."

Before dismissing this subject, it is important to ponder not only the impact of P.L. 89-97 on GPPPs, but the potential impact of GPPPs on P.L. 89-97.

Meaningful figures of performance under P.L. 89-97 are not yet available. We have already noted, however, that for reasonably comparable general population, GPPPs have shown significantly less utilization of acute general hospital beds. Thus, in the Steelworkers' Study, the differential was 1,032 vs. 570 hospital days per 1,000 per annum. In the Study of the Federal Employees' Health Benefits Program covering 6¾ million people, there was 40 percent less utilization of acute general hospital beds.

Repeated comparisons of the utilization of acute general beds by the HIP enrollment with comparable NYC Blue Cross population show a decrease equal to 20 percent.

Both HIP and Kaiser report that the use of acute general beds by their "over 65" enrollees shows little, if any, difference from that of their respective communities.

Figures for the last available year show that in Detroit, Community Health Association members used a total of 674 days per 1,000 members for the year (including hospitalization in other than CHA facilities), whereas Michigan Blue Cross subscribers (Statewide) showed 1,444 days per 1,000 for a comparable period.

Crude figures for the "over 65" CHA and Michigan Blue Cross populations last year are also available. At least three major, uncorrected factors must be kept in mind: (1) Blue Cross is dealing with 318,500 individuals compared to 2,800 for CHA; (2) CHA "over 65" age is known to be 72 – Blue Cross "over 65" age is not available but may well be considerably older; and (3) the mix of singles and couples may be quite different, as well as group vs. individual enrollment.

	Michigan Blue Cross "Over 65"	CHA "Over 65"
Admission Rate Per 1000 Per Annum	285	193
Total Days Per 1000 Per Annum	3,968	2,478

Without further speculation, let us consider the cost, or the potential saving, represented by one-day hospital stay, per admission under P.L. 89-97

Title XVIII using conservative figures.

Admission Rate Per 1000 Per Annum	250
Admission Rate Per 1,000,000 Per Annum	250,000
Total Admissions — 19,000,000 Beneficiaries (1 year)	4,750,000
Hospital Cost per Day at $45	$213,750,000
Plus Cost Per Medical Service Per Day at $10	47,500,000
Total Cost, or Saving, One Day	$261,250,000

No reliable figures can be used to add to this conservative estimate of hospital per diem cost for Title XVIII the corresponding hospital per diem costs for the concurrently operating Title XIX. Programs vary widely in the 25 states in which they are operated, and the composition of the population is unknown. Two facts, however, can be relied upon: (1) the composition of the Title XIX population will be more representative of the general population than Title XVIII (a population in which the economies of GPPPs have been documented), and (2) the total number of people eventually covered by Title XIX may be twice the number now covered under Title XVIII.

In any program in which the saving of a single day of hospitalization may eventually amount to something in excess of one-half billion dollars, the wisdom of an open-end, cost-plus type of remuneration to institutions and the luxury of payment for medical care by a fee for a service are bound to come under careful scrutiny.

Dependent on the degree to which GPPPs are allowed to continue their existing manner of providing services, there is reason to believe the involvement of GPPPs with P.L. 89-97 will grow in the years ahead. They will become attractive to government at the federal, state, and local levels as the costs of this program become apparent and comparative data become available which will allow valid comparisons between various patterns and systems of providing covered benefits.

P.L. 89-239 (Heart Disease, Cancer, and Stroke):

The regionalized concepts of the organization of medical services envisaged in this bill must be considered along with P.L. 89-749, which amends the Public Health Service Act to promote and assist in the extension and improvement of comprehensive health planning and public health services and provides for a more effective use of available federal funds for health planning and services.

The integration of many existing GPPPs with central facilities and related neighborhood centers, together with ongoing involvement with programs of both Public Health and community voluntary agencies, will be aided and abetted by these two laws.

Recent federal legislation has been helpful to GPPPs. Current indications are that it will continue in this direction in the future. This will be reinforced by the need for better control of costs and the growing pressure for a more effective organization of the distribution of total coordinated health services.

Other Considerations

(1) Outpatient Department:

The disappearance of the medically indigent patient will transform the existing hospital outpatient department. The staff of Roosevelt Hospital in New York City is already organizing, as a group, to handle these now private patients. While far removed from a GPPP, it is a first step. Hospital-based GPPPs have been encouraged by the planners as we have seen in the past. The Mt. Sinai Medical School in New York City is already planning the inclusion of a GPPP. More will follow in the next 20 years.

(2) Teaching:

Traditionally, patients used for teaching purposes in the past have been limited to those who lacked adequate funds to pay for private care at the particular time the care was needed. With the disappearance of "teaching material," groups composed of faculty members, during the next 20 years, may well assume responsibility for the medical care of a certain area surrounding the school through an arrangement by which those living within the area, who may elect to do so, will join the medical school prepayment program. Through this GPPP, an ideal teaching setting can be created from the highest specialty level in the "center of excellence," through the integrated community hospitals and extended care facilities, to the related neighborhood centers and associated home care teams reaching out to rural areas and involving the indigenous population.

(3) Automation:

During the next 20 years the effectiveness, savings, and costs of automation will simply be another, but potent, force toward making physicians and institutions more inter-related and mutually interdependent.

Conclusions

"For I dipt into the future,
Far as human eye could see,
Saw the vision of the world
And all the wonder that would be;"

With apologies to Tennyson, among the wonders of the medical world during the next 20 years will be:

(1) The health industry will become the largest in the country (only agriculture and construction are larger today).

(2) National expenditures for health will account for double the present percentage of the Gross National Product.

(3) The percentage of the gross amount contributed by the governmental sector will increase.

(4) Categorical approaches will gradually be coalesced to the point that access to comprehensive medical care will be made available to all.

(5) Consumers will play a greater role at the planning table.

(6) Consumers will become more concerned with the quality of care.

(7) The practice of medicine will be given greater visibility, and the medical profession will be required to give more of an accounting of the trust it has been given.

(8) There will be an orderly integration, coordination, and synchronization of all medical facilities and services, including voluntary agencies which will be the responsibility of regional planning councils that have been given legal authority and represent both producer and consumer.

(9) A growing appreciation that health involves physical, mental, and social well-being will add new faces to the medical care team.

(10) Solo practice with conventional fee for service will continue, but will decrease as coordinated comprehensive programs providing a broad spectrum of services become more available.

(11) As Public Health becomes more involved in medical care, Public Health and private health will become more difficult to distinguish.

(12) The physician will provide few and fewer services which can be performed as well by personnel with lesser training.

(13) Automation will encourage a clustering of institutions and providers of medical care.

(14) There will be a growing demand for a mechanism of prepaying for total medical care by a flat fee.

(15) The fundamental concepts of GPPP will endure.

(16) Federal legislation will encourage and strengthen further growth and development of GPPPs.

(17) During the next 20 years, group practice-prepayment direct service plans will flourish.

Michigan Community Colleges Train Many Health Workers

There seems to be no letup in Michigan's community college enrollments or in the paramedical training they offer.

The 16 community or junior colleges of 1960 with 27,690 students has skyrocketed now to 24 colleges with 68,000 attending classes. Four other districts have voted to establish junior colleges, and all are slated to open within the next two years.

Growth patterns give every indication of paralleling, if not exceeding, the records of the past few years, until all Michigan residents have the opportunity for higher education within reasonable commuting distance of their homes.

What the future holds in new courses of study in the paramedical field only time and demand can tell. The potential is great.

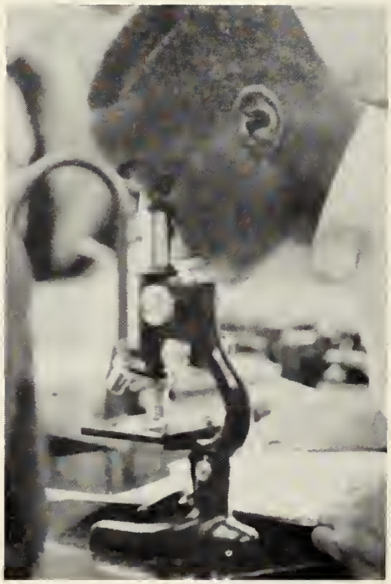
AT THE PRESENT TIME 20 of Michigan's community colleges offer curriculum in health-related occupations, ranging from dental and medical assistants and aides to laboratory and X-ray technicians, associate degrees in nursing to practical nursing and home health aides.

The new Washtenaw Community College in Ann Arbor, for example, included inhalation therapy in its initial course offerings. Such possibilities as electrocardiograph and radioisotope technology will hinge on demands for and desirability of cooperative programs with hospitals and medical schools.

The new federal Allied Health Professions Personnel Training Act of 1966 undoubtedly encourages the development of new programs in paramedics.

The Act authorizes a three-year program of assistance to institutions of higher learning to build teaching facilities and enrich teaching and training programs in allied health professions. While Congress did not allocate the full authorization for the program, Michigan is receiving $4 million this year under the lesser appropriation and may receive a great deal more in the next two years if the authorization is honored.

ONCE DIRECTED ALMOST exclusively to the first two years of a four-year college program and a source of general education to enrich post-high school learning, the community college has entered a new role of dual purpose. While continuing its standard undergraduate and cultural curricula, it has now branched into a variety of comprehensive programs to fill today's relentless search for qual-



ified semiprofessional and highly skilled technicians.

The implications of this unique and exciting potentiality for the allied health professions is of matched significance for business, industrial and societal interests. Where once a high school education sufficed, this era of computers, mechanization, electronics, and sophisticated technology demands much more. The community college is ideally constituted to fill these demands.

Vast and imperative as this task is, not to be overlooked is the community college's continuing role of supplying the first two years of the baccalaureate program — an increasingly vital function as the super-saturated classrooms and dormitories of the four-year institutions precipitate admission restrictions of increasing rigidity.

THE 1963 MICHIGAN Constitution states: "The Legislature shall provide by law for the establishment and financial support of public community and junior colleges which shall be supervised and controlled by locally elected boards. The Legislature shall provide by law for a state board for public community and junior colleges which shall advise the State Board of Education concerning general supervision and planning for such colleges and requests for annual appropriations for their support."

The coordination and the planning of not only the geographic districting, but also academic possibilities and needs is a responsibility of the State Board of Education in its development of a state plan for higher education.

Working with the recommendations of its constitutionally-established advisory Board for Public Community and Junior Colleges, the State Board is faced with decisions that must enhance strong community college structure and fulfill the promise of new colleges and new programs to serve all residents of the state.

The junior college movement in Michigan began in 1914 with the establishment of the Grand Rapids Junior College. Recent surveys of GRJC graduates reveal that many entered the professional fields.

AMA Speaker Discusses Junior College Role

Considerable attention was focused at the 1967 AMA National Congress of the Socio-Economics of Health Care on the present and potential roles of the Community colleges in helping to train health workers.

D. J. Mase, Ph.D., in his Congress address, predicted that soon one of every two students entering post-secondary institutions would enter a Community college.

In part, he said:

"There are approximately 800 junior colleges at the present time, and 190 are in the process of establishment (about 50 new ones opening a year). Junior colleges will have an estimated 2½ million students by 1970. At the present time one out of every three students entering post-secondary institutions are entering junior colleges.

"With the demand by society for an extension in health services, it becomes imperative to turn to the junior colleges to improve and extend their offerings for those students who wish to transfer for advanced degrees in the health occupations.

"We must establish quality programs in the junior colleges for students to receive the necessary educational and clinical training to perform their respective professional duties in these health occupations as well as to provide the extension of general education beyond high school."

These three photos show students enrolled in medical assistant and nursing programs at Highland Park College

Rural, Urban Living Blends In Michigan

Rural wives, and city wives too, will have more time for leisure as new food processing procedures are perfected. Breads and cakes now can actually be baked inside new flexible plastic containers, shown being tested here by a MSU graduate assistant in food science.

"The rural scene in Michigan is changing very rapidly."

That is the opening sentence in Research Report No. 37 on "Rural Michigan Now and in 1980," published by the MSU Cooperative Extension Service.

The Report points out that, "Projecting developments in the Michigan rural scene between now and 1980 is a difficult task."

Many imponderables, The Report says, cloud the picture.

Reasonable assumptions must be made, such as

1. No major war.
2. No major depressions.
3. Inflation of about 1.5 percent per year in consumer prices.
4. Average weather.
5. A more rapid development and adoption of new technology in the next 15 years than in the past 15 years.

John N. Ferris, of the MSU Department of Agricultural Economics, is Director of the MSU study which looks ahead to 1980.

Research Report No. 37, in part, offers these observations and forecasts about "Rural People and Rural Living — Now and in 1980:"

THE RURAL FAMILY in Michigan will be making a number of adjustments in the next 15 years. Two important adjustments will be the increasing number of families in rural Michigan and the shift of families from farm to nonfarm employment.

The size of both farm and rural nonfarm families averaged about 3.83 persons in 1960. In the past, large farm families were the rule as the children were valuable members of the labor force. This is less true at the present time.

Incomes of farm families from farm and nonfarm sources combined will increase sharply. It

URBAN, RURAL NONFARM AND RURAL FARM POPULATION OF MICHIGAN IN 1950, 1960, 1965 AND PROJECTED TO 1980

	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total	Percent change
	1950		1960		1965		1980		1960 to 1980
Urban	4,503,084	70.7	5,739,132	73.4	6,023,000	73.7	7,677,000	75.2	+33.8
Rural nonfarm	1,173,940	18.4	1,643,125	21.0	1,794,000	22.0	2,360,000	23.1	+43.6
Rural farm	694,742	10.9	440,937	5.6	353,000	4.3	167,000	1.1	—62.1
Total	6,371,766	100.0	7,823,194	100.0	8,170,000	100.0	10,204,000	100.0	+30.4

Based on the analysis of John F. Thaden, MSU Institute for Community Development, and quoted from Research Report No. 37, MSU Cooperative Extension Service.

s possible that farm families will average about 8,000 of disposable personal income per family y 1980, including off-farm income. Incomes of ural nonfarm families would be projected to bout $9,000 on the basis of recent trends.

The economic and social differences between he farm, the rural nonfarm and the urban populations will wane. Practically all Michigan farms re within one mile of an improved road. Nearly ll farm families own automobiles, trucks or both.

Advancements in transportation will continue o bring improvements in health care; in recreational, shopping and educational facilities; in conomic opportunities; and in opportunities for ocial interchange. Radio and television have also ontributed to the merging of rural and urban iving patterns. This has been demonstrated in rends in food consumption, clothing and housing.

Rural Michigan families, as others, will find an ncreasing range of clothing choices available to hem by 1980.

DURING THE NEXT 15 years, rural families vill continue to live primarily in single family ouses situated on their own tract of land. Urban amilies will be shifting more to high-rise and nedium-rise apartments or to clustered houses vith shared park areas. Land use is becoming increasingly intensive, and in time, land will become so scarce and so expensive that high density se will be inevitable.

The farm homestead will ultimately, though erhaps not by 1980, be replaced by some sort of nanufactured house that can be assembled on the ite. This will become necessary because local eople are fast losing their technical skills, and rban builders prefer not to go into outlying reas to build.

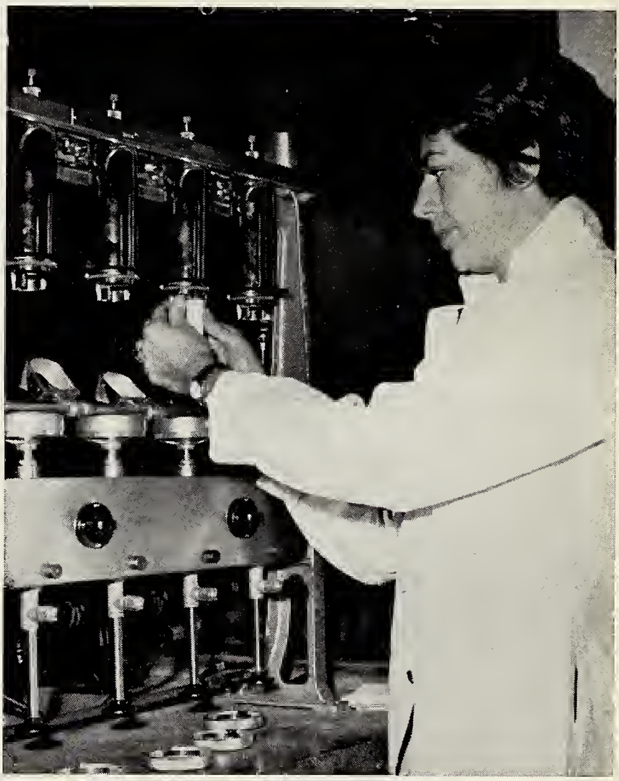
Mobile homes will come into greater use both or young couples wishing to live near their parents on the farm and for hired labor.

Marriage, divorce and remarriage rates in rural Michigan will remain high, as at present, but irth and death rates will both be lower. With ncreased leisure, earlier retirement, and an even onger life span, husband and wife will have more ime together, especially after the children have eft home.

CHANGES FACING Michigan rural youth will e education, position in society, value systems, nd patterns of leadership necessary to help youth djust to their new environment.

All youth will be required to have a much igher level of general education. Much of the vocational training, both formal and informal, will ikely be delayed until after secondary education s completed.

(Editor's Note: Michigan physicians, especially those in rural and suburban communities, will be interested in the MSU Cooperative Extension Service Research Report No. 37 about "Rural Michigan Now and in 1980." Interested MSMS members may obtain a copy from the MSU College of Agriculture, East Lansing)



The MSU College of Agriculture and Michigan Agricultural Experiment Stations are constantly helping rural — and urban — residents through research for better foods and improved human nutrition. Dorothy Arata, Ph.D., MSU foods and nutrition researcher, puts fatty liver tissues on an extractor for fat analysis as part of her study aimed ultimately at finding a treatment for fatty livers in humans. She predicts that this amino acid deficiency will probably become an increasing problem among humans as they consume more and more synthetic foods.

Insights in Vietnam Medical Care Described at Naval Reserve Seminar

BY PETER HOHEISEL
MSMS STAFF

"Unlike other wars, battle fatigue in Vietnam seems to be less of a problem," said Vice-Admiral Robert B. Brown, commenting on the medical aspects of the Vietnam war at a three-day scientific seminar on trauma at the Navy base on Grosse Ile.

"The reason for this," continued the Surgeon General of the Navy and the Marines, "is that men are not under battle tension for long periods of time. It gives the human psyche a chance to unwind."

The meeting was sponsored by the 9th Naval District for Medical Reserve Physicians from 13 states.

"Another problem we have met," Admiral Brown said to the over 100 officers in attendance, "is wet foot syndrome. Monsoon weather exposes soldiers feet to long periods of wetness. The skin cracks and peels. To combat this we have developed a 100% silicone ointment which the soldier puts on his feet once a day and it is reducing the problem a great deal."

Vice-Admiral Robert B. Brown, M.D., second from left, Surgeon General of the Navy and the Marines, who recently spoke at a scientific seminar in Grosse Ile for Medical Reserve Officers. Left to right are Capt. Sidney Adler, M.D., Commanding Officer of the U.S. Medical Naval Reserve Company of Michigan; Vice-Admiral Brown, M.D.; Rear Admiral J. W. Albrittain, M.D., 9th Naval District Medical Officer, and Captain Thomas Canty, M.D., Head of the Reserve Officer Training Program.

The helicopter, Admiral Brown reported, has virtually eliminated the delays which used to seem almost endless in the treatment of the wounded man. Formerly the man went first to battalion aid station, then to field hospital, evacuation hospital, and finally to general hospital; today a wounded man can be on one of the Navy's two 750 bed hospital ships, the Sanctuary and the Repose, within an hour of being hit from practically anywhere in Vietnam.

"He goes directly from combat to the best medical care available today," said Admiral Brown. Never before have we provided better or more rapid and definitive medical care."

Frozen blood is another development of the Navy. At present there are three frozen blood banks in Vietnam.

When not working on military personnel, navy doctors and nurses sometimes give medical aid to South Vietnamese civilians, Admiral Brown reported.

Captain Sidney Adler, MSMS Council member, who as commanding officer of the U.S. Naval Medical Reserve Company of Michigan organized the meeting, observed that Medical Company 9-5 of Detroit was the first Naval Medical Reserve Company to put on a seminar devoted to trauma.

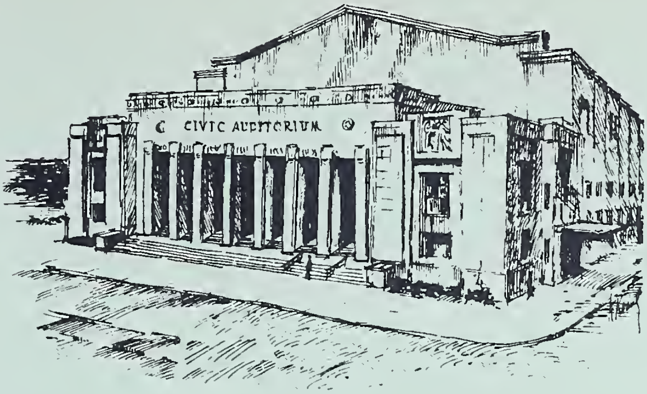
The three-day scientific session continued the tradition of excellence of the Michigan company, symbolized in its recent reception of a plaque designating it the top Medical Naval Reserve company in the United States.

"The meeting was both a three-day refresher course on trauma and a report by the Navy on Vietnam war casualties. Getting so many outstanding men together to speak was one of the best features of the seminar," Doctor Adler said.

Another highlight of the seminar was a presentation of Admiral J. W. Albrittain, Chief of the naval hospital at Great Lakes. He spoke on newer hospital and training techniques.

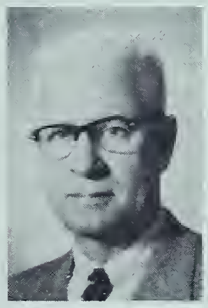
Several Michigan men gave scientific papers at the meeting. From Wayne State University were James R. Lloyd, M.D., Joseph L. Posch, M.D., H. Harvey Gass, M.D., and Elisha S. Gurdjian, M.D.; from University of Michigan was Irving Feller, M.D.; from several Detroit area hospitals were Fredrick Weissman, M.D., Paul G. Firnschild, M.D., Thomas Gahagan, M.D., and Herman D. Scarney, M.D.

Pull out these Blue Pages . . . Here's Your Annual Session Program

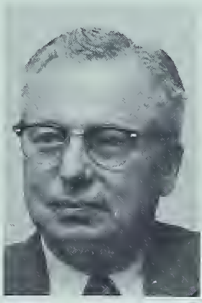


PROGRAM

1967 Annual Scientific Session
Grand Rapids Civic Auditorium/Pantlind Hotel
September 27-28-29, 1967



H. H. Hiscock, M.D.
Annual Session
General Chairman



H. A. Towsley, M.D.
Chairman
Program Committee

D. L. Kessler, M.D.
Local Chairman
Of Arrangements

C. E. Booher, M.D.
Chairman, Scientific
Exhibits Committee

ON THESE BLUE PAGES . . . YOU'LL FIND:

852-861 Annual Session Program
862 Guest Editorial, Doctor Towsley
863 Plans for MSMS Sections
863 Curbstone Consultations
863 New Plan for Luncheons
864 Scientific, Technical Exhibits
864 MDPAC Breakfast
864 Meet the Leaders
864 All on One Floor
864 State Society Dinner Dance
865 Public Forum on Sex Education
865 Doctor-Wife Art Exhibit
866 Woman's Auxiliary Convention
866 Medical Assistants Convention

ANNUAL SCIENTIFIC SESSION PROGRAM

WEDNESDAY MORNING, SEPTEMBER 27

CHOOSE FROM THREE CONCURRENT SESSIONS*

CIVIC AUDITORIUM

8:45 - 10:00

BLACK & SILVER ROOM

Groups Cooperating:

MSMS Section on Internal Medicine

Michigan Heart Association

Comprehensive Care in Coronary Artery Disease ***(Symposium)***

Moderator — Park W. Willis, MD, Professor of Internal Medicine, University of Michigan Medical School

Preventions Coping with Risk Factors

Henry W. Blackburn, MD, Associate Professor, Physiology and Hygiene, University of Minnesota

Medical Management

Keith H. Averill, MD, Director, Cardiovascular Department, Research Hospital and Medical Center, Kansas City, Missouri

Evaluating the Coronary Circulation: Does "Revascularization" Help?

Harvey G. Kemp, MD, Peter Bent Brigham Hospital, Boston

Heart Revascularization — Rationale and Results

William H. Sewell, MD, Chief, Cardiac Surgery, Guthrie Clinic, Sayre, Pennsylvania

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ROOM C

MSMS Committee Cooperating:

Maternal Health

Abortion — Pro and Con ***(Symposium)***

Moderator: J. Robert Willson, MD, Professor of Obstetrics and Gynecology, University of Michigan School of Medicine

B. James George, Jr., A.B., J.D. Professor of Law, University of Michigan Law School

Sprague H. Gardiner, MD, Professor of Obstetrics and Gynecology, University of Indiana Medical School

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ROOM D

MSMS Committee

Cooperating: Education Liaison

Paramedical Personnel — Extra Hands for the Doctor

Moderator: Harold J. Meier, MD, Chairman, MSMS Committee on Paramedical Education, Coldwater

William G. Birch, MD, Kalamazoo

Robert E. Kinsinger, PhD, W. K. Kellogg Foundation, Battle Creek

Don Marshall, MD, Chairman, MSMS Committee on Education Liaison, Kalamazoo

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10:00 - 10:45

Coffee Break and Intermission to View the Exhibits

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* See Page 853 for the continuous Curbstone Consultations Wednesday morning.

Continued: WEDNESDAY MORNING

10:45 - 12:00

CHOOSE FROM THREE CONCURRENT SESSIONS

BLACK & SILVER ROOM

Groups Cooperating:
MSMS Section on
nternal Medicine

Michigan Heart
Association

Comprehensive Care in Coronary Artery Disease *(Symposium continued)*

Moderator: Larry H. Birch, MD, Associate Professor of Internal Medicine, Department of Postgraduate Medicine, University of Michigan Medical School

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ROOM C

MSMS Section
Cooperating:

Dermatology

Collagen Disease — Its Skin Manifestations *(Seminar)*

Moderator and Discussant: E. Richard Harrell, MD, Professor of Dermatology, University of Michigan Medical School

Thomas K. Burnham, MD, Associate Physician, Department of Dermatology, Henry Ford Hospital, Detroit

Charles G. Mendelson, MD, Henry Ford Hospital, Detroit

ROOM D

Groups Cooperating:

MSMS Section on
Anesthesiology

Michigan Society of
Anesthesiologists

Obstetrical Anesthesia *(Round Table Discussion)*

Frank Moya, MD, Professor and Chairman, Department of Anesthesiology, University of Miami School of Medicine, Florida

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SPECIAL FEATURE

9:00 - 12:00 and 2:00 - 5.00

RED ROOM

Curbstone Consultations

Paper Work and Governmental Medical Care Programs

Moderator: J. Kenneth Altland, MD, Medical Director, Department of Social Services, State of Michigan

Lee Forest, Regional Office, Social Security Administration, Chicago

James L. Hall, Assistant to Director of Medical Services, Department of Social Services, State of Michigan

R. Bernard Houston, J.D., Director, Department of Social Services, State of Michigan

Jed Kearney, Michigan Blue Shield, Detroit

Robert G. Rice, MD, Director, Bureau of Maternal and Child Health, Michigan Department of Public Health

Harold L. Tremain, MD, Michigan Blue Cross, Detroit

12:00 - 2:00

CIVIC AUDITORIUM
LOWER LEVEL

**GENERAL LUNCHEON FOR ALL REGISTRANTS
WITH THE SPEAKERS OF THE DAY**

WEDNESDAY AFTERNOON, SEPTEMBER 27

CHOOSE FROM THREE CONCURRENT SESSIONS

2:00 - 3:15

BLACK & SILVER ROOM

MSMS Sections Cooperating:

General Practice

Internal Medicine

Pediatrics

The New Physician *(Seminar)*

Moderator: Andrew D. Hunt, MD, Dean, College of Human Medicine, Michigan State University

The New Physician

William R. Willard, MD, Vice President, Medical Center, University of Kentucky

The Pitfalls of Implementing the New Physician

Richard M. Magraw, MD, Director, Comprehensive Clinic Program, University of Minnesota College of Medical Services

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ROOM C

MSMS Sections Cooperating:

Allergy & Applied Immunology

General Practice

Internal Medicine

Pediatrics

Primary Immunologic Deficiency Diseases *(Seminar)*

Moderator: Kenneth P. Mathews, MD, Professor of Internal Medicine, University of Michigan

Raymond D. A. Peterson, MD, Associate Professor of Pediatrics, University of Chicago Medical School

Henry N. Claman, MD, Assistant Professor of Internal Medicine, University of Colorado Medical School *(Discussant)*

ROOM D

Groups Cooperating:

MSMS Committee on Alcoholism & Drug Addiction

MSMS Sections on
General Practice
Internal Medicine
Neurology & Psychiatry
Pediatrics

Alcoholism — Recognizing a Medical Iceberg *(Round Table Discussion)*

Melvin L. Selzer, MD, Associate Professor of Psychiatry, University of Michigan Medical School

Donald L. Damstra, MD, Brighton Hospital, Michigan

3:15 - 4:15

Coffee Break and Intermission to View Exhibits

Continued: WEDNESDAY AFTERNOON

4:15 - 5:30

CHOOSE FROM THREE CONCURRENT SESSIONS

LACK & SILVER ROOM

SMS Sections
ooperating:

eneral Practice

nternal Medicine

ediatrics

Regional Medical Plans for Heart, Cancer, and Stroke *(Seminar)*

Moderator: Don Marshall, MD, MSMS Representative to and Vice-President of the Michigan Association for Regional Medical Programs, Inc.

William N. Hubbard, Jr., MD, Dean, University of Michigan Medical School

James T. Howell, MD, Executive Director, Henry Ford Hospital, National Advisory Council for Regional Medical Programs, Detroit

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OOM C

SMS Sections
ooperating:

llergy & Applied
mmunology

eneral Practice

nternal Medicine

ediatrics

Secondary Immunologic Deficiency Diseases *(Seminar)*

Moderator: Kenneth P. Mathews, MD, Professor of Internal Medicine, University of Michigan

Henry N. Claman, MD, Assistant Professor of Internal Medicine, University of Colorado Medical School

Raymond D. A. Peterson, MD, Associate Professor of Pediatrics, University of Chicago Medical School *(Discussant)*

OOM D

roups Cooperating:

SMS Committee on
lcoholism &
rug Addiction

SMS Sections on
eneral Practice
nternal Medicine
ediatrics

Drug Dependence *(Round Table Discussion)*

Herbert A. Raskin, MD, Clinical Associate Professor, Department of Psychology, Wayne State University School of Medicine

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MSMS GRATEFULLY ACKNOWLEDGES PROGRAM GRANTS FROM THE FOLLOWING:

— THE UPJOHN COMPANY
— WARNER-CHILCOTT LABORATORIES
— MICHIGAN CANCER COORDINATING COMMITTEE
— MICHIGAN HEART ASSOCIATION

THURSDAY MORNING, SEPTEMBER 28

CHOOSE FROM THREE CONCURRENT SESSIONS

8:45 - 10:00

BLACK & SILVER ROOM

MSMS Sections Cooperating:

General Practice

Gynecology & Obstetrics

Pediatrics

Emergencies in the Delivery Room *(Seminar)*

Moderator: T. N. Evans, MD, Professor and Chairman, Department of Obstetrics-Gynecology, Wayne State University School of Medicine

Obstetrician-Gynecologist

Frederick P. Zuspan, MD, Chief, Department of Obstetrics-Gynecology, University of Chicago

Pediatric Emergencies in the Delivery Room

Bruce D. Graham, MD, Children's Hospital, Columbus, Ohio

Anesthesiologist

Otto C. Phillips, MD, Pittsburgh

ROOM C

MSMS Section Cooperating:

Neurology & Psychiatry

Recognition and Management of the Suicidal Patient *(Seminar)*

Moderator: Kenneth E. Pitts, MD, Grosse Pointe

Viggo W. Jensen, MD, Grosse Pointe

Thomas A. Petty, MD, Grosse Pointe

ROOM D

MSMS Section Cooperating:

Occupational Medicine

Medical Intelligence Systems — Computer Oriented *(Round Table Discussion)*

W. T. Stille, Medical Department, Eastman Kodak Company, Rochester, New York

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10:00 - 10:45

Coffee Break and Intermission to View Exhibits

Continued: THURSDAY MORNING

10:45 - 12:00

CHOOSE FROM FOUR CONCURRENT SESSIONS

LACK & SILVER ROOM

SMS Section
ooperating:

eneral Practice

The Use and Abuse of Common Therapeutic Agents *(Seminar)*

Moderator: Francis P. Rhoades, MD, Chairman, Michigan Academy of General Practice Scientific Assembly, Detroit

Edward A. Carr, MD, Professor of Pharmacology and Associate Professor of Internal Medicine, University of Michigan Medical School, and Director, Upjohn Center for Clinical Pharmacology, Ann Arbor

F. Robert Fekety, Jr., MD, Assistant Professor of Medicine, Johns Hopkins Hospital, Baltimore

Lawrence Power, MD, Associate Professor of Medicine and Chief, Endocrinology and Metabolism, Wayne State University School of Medicine

OOM C

SMS Sections
ooperating:

rthopedic Surgery

ediatrics

Common Foot Problems in Children *(Round Table Discussion)*

Nicholas J. Giannestras, MD, Assistant Clinical Professor, Orthopaedic Division, Department of Surgery, University of Cincinnati School of Medicine, Cincinnati

OOM D

roups Cooperating:

SMS Section on
urgery

ichigan Cancer
oordinating Committee

Carcinoma of the Esophagus — Radiation vs. Surgery *(Seminar)*

Moderator: Joseph A. Witter, MD, Head of Department of Surgery, Highland Park General Hospital, Michigan

Herbert D. Adams, MD, Department of General Surgery, Lahey Clinic Foundation, Boston

Isadore Lampe, MD, Professor of Radiology, University of Michigan Medical School

ED ROOM

SMS Committee
ooperating:

ducation Liaison

Paramedical Personnel — Extra Hands for the Doctor *(Discussion)*

Moderator: Harold J. Meier, MD, Chairman, MSMS Committee on Paramedical Education, Coldwater

William G. Birch, MD, Kalamazoo

Robert E. Kinsinger, PhD, W. K. Kellogg Foundation, Battle Creek

Don Marshall, MD, Chairman, MSMS Committee on Education Liaison, Kalamazoo

12:00 - 2:00

**IVIC AUDITORIUM
OWER LEVEL**

**GENERAL LUNCHEON FOR ALL REGISTRANTS
WITH THE SPEAKERS OF THE DAY**

THURSDAY AFTERNOON, SEPTEMBER 28

CHOOSE FROM FOUR CONCURRENT SESSIONS

2:00 - 3:15

BLACK & SILVER ROOM

MSMS Sections Cooperating:

Neurological Surgery

Orthopedic Surgery

Surgery

Urology

Surgical Emergencies *(Symposium)*

Moderator: Alexander J. Walt, MD, Assistant Dean, Professor and Chairman, Department of Surgery, Wayne State University School of Medicine

Emergency Surgery in Children

H. William Clatworthy, MD, Professor and Chief, Department of Pediatric Surgery, Children's Hospital, Columbus, Ohio

Orthopedic Surgery

William S. Smith, MD, Professor of Surgery and Head of Orthopedics, University of Michigan Medical School

Cardiac Shock

Robert F. Wilson, MD, Receiving Hospital, Detroit

Neurological Surgery

A. Earl Walker, MD, Professor of Neurological Surgery, Johns Hopkins Hospital, Baltimore

Urological Surgery

James M. Pierce, MD, Wayne State University School of Medicine

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ROOM C

MSMS Section Cooperating:

Plastic Surgery

Decision Between Radiation and Surgery in Treatment of Cancer of the Head and Neck *(Round Table Discussion)*

S. Stanley Hoffmeister, MD, Roswell Park Memorial Institute, Buffalo

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ROOM D

Groups Cooperating:

MSMS Section on Public Health & Preventive Medicine

MSMS Committee on Venereal Disease Control

Venereal Disease on the Rampage and What You Can Do about It *(Seminar)*

Moderator: Arthur C. Curtis, MD, Professor and Chairman, Department of Dermatology, University of Michigan Medical School

Joseph C. Cerny, MD, Assistant Professor of Surgery, University of Michigan Medical School

Benjamin Schwimmer, MD, Director of Social Hygiene Clinic, Detroit Health Department

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RED ROOM

MSMS Section Cooperating:

Otolaryngology

Facial Trauma *(Round Table Discussion)*

John T. Dickinson, MD, Associate Clinical Professor of Otolaryngology Mercy Hospital, Pittsburgh

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3:15 - 4:15

Coffee Break and Intermission to View the Exhibits

Continued: THURSDAY AFTERNOON

4:15 - 5:30

CHOOSE FROM FOUR CONCURRENT SESSIONS

ACK & SILVER ROOM	Surgical Emergencies *(Symposium continued)*
OM C SMS Section operating: ostetrics & necology	Thoughts about Toxemia of Pregnancy *(Round Table Discussion)* Frederick P. Zuspan, MD, Chief of the Department of Obstetrics- Gynecology, University of Chicago Medical School
OM D SMS Section operating: ctology	Rectal Bleeding *(Seminar)* Moderator: Don W. McLean, MD, Detroit Howard G. Benjamin, MD, Grand Rapids George T. Bradley, MD, Detroit Maus W. Stearns, MD, New York City
D ROOM oups Cooperating: MS Section on hthalmology chigan Ophthal- logical Society	Naso-orbital Fractures and Traumatic Deformities of the Medical Canthus *(Round Table Discussion)* William C. Grabb, MD, Assistant Professor of Surgery, Section of Plastic Surgery, University of Michigan Medical School

THURSDAY EVENING, SEPTEMBER 28

8:00

LLROOM NTLIND HOTEL oups Cooperating: MS Section on blic Health & ventive Medicine MS Committee on ternal Health	Family Life and Sex Education — Neglect or Overemphasis *(Public Forum)* Esther D. Schulz, PhD, RN, Associate Director for Education Services, Sex Information Council of the United States, New York City Chairman: Robert E. Rowe, MD, Port Huron Secretary: Eleanor P. Skufis, MD, Adrian

FRIDAY MORNING, SEPTEMBER 29

CHOOSE FROM THREE CONCURRENT SESSIONS

8:45 - 10:00

BLACK & SILVER ROOM

MSMS Section Cooperating:

Pediatrics

Controversies in the Management of Children — The Tonsil Problem, When to Open Ears, Urinary Infection ***(Seminar)***

Moderator: Paul V. Woolley, MD, Pediatrician-in-Chief, Children's Hospital of Michigan, Detroit

William J. Oliver, MD, Professor and Chairman, Department of Pediatrics, University of Michigan Medical School

Walter P. Work, MD, Professor and Chairman, Department of Otorhinolaryngology, University of Michigan Medical School

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ROOM C

MSMS Section Cooperating:

Gastroenterology

The Management of Portal Hypertension ***(Round Table Discussion)***

Moderator: Bernard M. Schuman, MD, Associate Physician, Division o Gastroenterology, Henry Ford Hospital, Detroit

Charles G. Child, III, MD, Professor and Chairman, Department o Surgery, University of Michigan Medical School

Benjamin H. Sullivan, MD, Staff Member, Department of Gastroenterology, Cleveland Clinic, Cleveland

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ROOM D

Groups Cooperating:

MSMS Section on Gynecology & Obstetrics

MSMS Committee on Maternal Health

What's Good and What's Bad With The Newer Contraceptives ***(Round Tabl Discussion)***

Moderator: Harrison C. Visscher, MD, Grand Rapids

Wm. J. Ledger, MD, Ann Arbor

Darrell E. Statzer, MD, Detroit

10:00 - 10:45

Coffee Break and Intermission to View the Exhibits

Continued: FRIDAY MORNING

10:45 - 12:00

CHOOSE FROM THREE CONCURRENT SESSIONS

ACK & SILVER ROOM
MS Section
operating:
diatrics

The Management of Common Pediatric Problems *(Pediatric Clinical Conference)*

Moderator: Paul V. Woolley, MD, Pediatrician-in-Chief, Children's Hospital of Michigan, Detroit

Bruce D. Graham, MD, Professor and Chairman, Department of Pediatrics, College of Medicine, Ohio State University

William J. Oliver, MD, Professor and Chairman, Department of Pediatrics, University of Michigan Medical School

John R. Wilson, MD, Grand Rapids

OM C
MS Section
operating:
stroenterology

The Use of the Gastro-Camera *(Wet Clinic)*

Robert J. Priest, MD, Physician-in-Charge, Division of Gastroenterology, Henry Ford Hospital, Detroit

Benjamin H. Sullivan, MD, Staff Member, Department of Gastroenterology, Cleveland Clinic, Cleveland

Daniel Joseph Fall, MD, Instructor in Internal Medicine, University of Michigan Medical School

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OM D
MS Section
operating:
diology

Gross Rates of Colonic Polyps and Carcinoma *(Round Table Discussion)*

Leo S. Figiel, MD, Detroit
Steven J. Figiel, MD, Detroit

12:00 - 2:00

IC AUDITORIUM
VER LEVEL

GENERAL LUNCHEON FOR ALL REGISTRANTS
WITH THE SPEAKERS OF THE DAY

ADJOURNMENT

The Physician, Continuing Education, And the MSMS Annual Session . . .

BY HARRY A. TOWSLEY, M.D., CHAIRMAN,
MSMS ANNUAL SESSION
PROGRAM COMMITTEE

In the April issue of *Michigan Medicine* our President, C. Allen Payne, M.D., made an unusually timely plea to the members of MSMS in his editorial, "The Need for Continuing Medical Education."

In his closing paragraph, he states: "I cannot too strongly emphasize that basic to the resolution of the gap between medical knowledge and day-to-day practice is the rededication of physicians to individual responsibility in providing themselves with the knowledge necessary to treat their patients with the best that medicine can provide."

AS PHYSICIANS, we are aware of the great scientific advances being made each day in techniques to save and prolong lives, to alleviate suffering and to reduce the morbidity and mortality of mankind.

With or without approval, physicians also recognize the tremendous social changes affecting the delivery of medical care, the changing moral standards and the shifts in society's concepts of family life and planning, all of which have added new dimensions to their burdens of responsibility for their patients.

The overwhelming pressures for medical services, created by spiraling population increases, governmental sponsored health care programs and the affluence of the society in which we live, have combined to place Herculean roadblocks in the path of the physician in his quest for continuing education.

TIME FOR READING, reflection and interpretation of new information skimmed from the tidal wave of new medical knowledge appearing in scientific journals has been reduced to an infinitesimal minimum of that required to enable the physician to broaden and up-date his ability to serve his patients and his community better in the alleviation of human suffering.

Caught in the jet stream of scientific advance, changing social, moral and political values, th physician's task of decision-making, necessary i the provision of good medical service and wis counseling for his patients, has become a mon mental undertaking.

In recognition of these vast changes, the nee for available, short comprehensive progran packed with new and proved scientific inform tion, correlated with diagnostic and therapeut procedures that have withstood the tests of tin and practice in patient understanding and car becomes vividly apparent to the physician ded cated to the precepts of his professional calling.

TO ASSIST ITS members in reducing the ba riers separating new found scientific knowledg arising in research laboratories and provi grounds, and that which is practiced in the fro lines of daily patient care, the MSMS Progra Committee for this the 102nd Annual Session an the officers of the Michigan State Medical Socie take great pride in presenting a new and uniq program.

In developing this year's program, the Co mittee, with the cooperation of Section Officer has arranged a two and one-half day session, co posed of seminars, roundtable discussions ar clinical conferences, encompassing and bringi together the many disciplines in the practice medicine.

This will provide those attending an opportuni of selecting one of three different programs ru ning simultaneously at any hour during the s sion.

In former years, the general sessions of MSM made up of unrelated lectures covering a host topics, served to bring much useful informati to those in attendance. Recent increases in sp cialization and the rapid growth of specialty s tions, however, have served to franctionate the tendance at general sessions to an embarrassi degree.

Therefore, the new format was adopted.

THE INTIMACY of round table discussio seminars and clinical conferences provides an u usual opportunity for every doctor present to me

Have Lunch with the Speakers" Idea romoted for 1967 Annual Session

Physicians whose questions did not get answered at the scientific meetings, ier because they thought of them too late or there was not enough time, l have a chance to meet the speakers for informal discussion during the cheons at the MSMS Annual Session this year.

Signs indicating where the guest speakers will sit during the luncheon will physicians the opportunity to have lunch with any of the speakers. Prior he luncheon, which will be held on the lower level of the Civic Auditorium, sh bar will be set up.

Annual Session Program Committee is enthusiastic about this opportunity et individual questions resolved. Tickets for the luncheons, will be available he MSMS Registration Area in the Civic Auditorium.

The one-big-luncheon has been scheduled for noon Wednesday and Thurs-, September 27 and 28.

ections Cooperate Planning Blocks A/S Program

fficers of MSMS Sections have worked closely h the Scientific Program Committee to develop 1967 Scientific Program at the Annual Session.

ll physicians are invited to the presentations arged by the Sections. Talks are designed for ad interest in hospital practice and the phyan's office.

ection Business Meetings will be conducted at end of program segments. Non-members will free at that time to visit the scientific and techal exhibits which are mixed together for the t time this year.

Medicare, Medicaid Officials to Hold "Curbstone Talks"

Officials from the Michigan agencies operating Medicare and Medicaid will open themselves to questions, complaints, or compliments from the physicians attending the Annual Session.

On both Wednesday and Friday mornings, September 27 and 29, from 8:45 until noon, representatives of the State Departments of Health and Social Welfare, the Social Security Regional Office, Blue Cross and Blue Shield will be present to discuss problems with individual physicians.

No formal papers will be given. Emphasis will be on personal assistance to doctors.

The Program Committee developed these "Curbstone Conferences." J. K. Altland, M.D., coordinator of the sessions, is implementing them.

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ntinued: The Physician, Continuing Education . . .

sonally and talk over mutual problems, not y with the scheduled discussants, but with his rs and colleagues as well. Physicians from dical centers throughout the state and nation, wn for their scientific contributions through earch, effective teaching ability, administrative gment and, in particular, their thoughtful conration in the care of patients, have been seed as participants for this outstanding prom.

glance at the daily scheduled program will icate the wide variety of subjects offered, ging from discussions in depth of specific diseases to problems related to social and economic changes affecting the practice of medicine. Every physician, whether specialist, generalist, or administrator will find multiple opportunities to obtain much useful and new information applicable to his daily practice.

Make your plans now to take advantage of the opportunities being offered to gain new and useful information, renew old acquaintances and make new ones and relax, if only for a few days, from your busy practice at this year's session of MSMS! You owe it to yourself, to your patients and to your family.

Two-Fold Treat

One of the colorful aspects of the MSMS Annual Scientific Session in Grand Rapids, September 27-28-29 will be the interesting array of exhibits. This year MSMS again will provide two classes of exhibits:

SCIENTIFIC
TECHNICAL

Take the time to inspect each one — not just a look-see . . . but a real indepth study. You will be surprised at the wealth of new information.

The 1967 MSMS House of Delegates will be September 24-25-26 followed by the Annual Session at the Grand Rapids Civic Auditorium and the Pantlind Hotel.

Concentrate All '67 Activities On Main Floor

Good news for physicians who remember walking up and down stairs to get from exhibits to scientific meetings during previous annual sessions in Grand Rapids is the new floor plan announced for the 1967 meeting.

This year the registration desk and exhibits will all be on the first floor, rather than in the basement. The scientific meetings rooms also will be on the first floor. The exhibition hall this year will be in the big Civic Auditorium ballroom, which in past was used only for some meal and social functions.

The only function to be held on the lower level will be the luncheons.

Intermission periods between scientific sessions will give the doctors additional opportunity to visit the exhibits.

Ford to Address MDPAC Breakfast

Gerald R. Ford, Congressman from Michigan's Fifth District and Minority Leader of th House of Representatives, will be the feature speaker at an MDPAC breakfast September 2 at 7:30 a.m., during the Annual Session.

All physicians and their wives are invited t attend the breakfast.

Vernon V. Bass, M.D., Saginaw, Chairman o MDPAC, recently firmed up the program whe the MDPAC delegation visited Washington t confer with Congressman Ford and others.

Meet the Leaders

To develop as impressive a program as the 19 MSMS Annual Session requires much thinki and doing.

Some of the chief architects behind the session Grand Rapids are: Harold H. Hiscock, M.D., Flint, General Chairman of Arrangements; D L. Kessler, M.D., Grand Rapids, Local Chairm of Arrangements; Craig E. Booher, M.D., Gra Rapids, Chairman of the Scientific Exhibits Co mittee.

Harry A. Towsley, M.D., Ann Arbor, is aga Chairman of the Annual Session Program Co mittee. Serving with Dr. Towsley on his comm tee are Thomas McKean, M.D., Vice-Chairm and F. P. Rhoades, M.D., both of Detroit; W. Baum, M.D., Grand Rapids; K. H. Johnson, M. Lansing; R. L. Rapport, M.D., Flint; and S. Winslow, M.D., of Battle Creek.

Dinner Dance Set for September 27; Harris to Be Installed New President

Good food, enjoyable company, and soft music await doctors and th wives on Wednesday evening, September 27, in Grand Rapids.

That is the time chosen for the Annual State Society Dinner Dance, pleasant part of the MSMS Annual Session when doctors and their wives vote an entire evening to entertainment.

Always an impressive part of the Dinner Dance is the installation of MSMS President. This year Bradley M. Harris, M.D., Ypsilanti, and now Pr dent-Elect, will take the oath of office at the evening affair.

"The Dinner Dance will be an exciting event! Plan now to attend a give yourself an evening of excellent food and fine entertainment." point of Annual Session planners.

Plan Sex Education Seminar; Invite Public

esponse to the open forum on VD during the 6 Annual Session was so great that MSMS plans imilar program devoted to Family Life Educa- n on Thursday evening, September 28, during 1967 Annual Session.

he program will be open to interested physi- ns and the public.

peaker for the meeting, to be held in the Ball om of the Pantlind Hotel, will be Esther D. ulz, Ph.D., R.N., Associate Director for Educa- n Services of the Sex Information Education uncil of the U.S.

The meeting will be sponsored by the Section on Public Health and Preventive Medicine of which, Robert E. Rowe, M.D., Port Huron, is the Chairman and Eleanor P. Skufis, M.D., Adrian, is the Secretary.

The meeting is also sponsored by the Committee of Maternal Health and its subcommittee on Lay Education. William W. Jack, M.D., Grand Rapids, is Chairman of the Maternal Health Committee and James E. Harryman, M.D., Muskegon, is Chairman of the Subcommittee.

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hysicians, Wives Urged o Enter '67 Art Show

Get out your paintbrushes, cameras, needles thread, and other art supplies and start now paring entries for the 1967 Doctors and Wives Show," urges Mrs. Lloyd A. Kammeraad, and Rapids, Show Chairman.

The Show," reports Mrs. Kammeraad, "is to held September 27-29 in Grand Rapids as a t of the MSMS Annual Session."

All doctors and their wives are encouraged to er their works."

The rules," the Chairman said, "are simple."

ntries are limited to members of the Michigan te Medical Society and their wives. All work st be the original work of the entrant. Each son is limited to four entries. Paintings must framed. Water colors, drawings, and prints must be matted or framed. Framed entries must be equipped with eyelets or wire suitable for hanging, as the works will be hung in exhibition.

There are seven classes of competition, adds Mrs. Kammerrad:

I. Painting: oil, polymer, encaustic acrylic, lacquer, etc.
II. Painting: watercolor, casein, tempera, pastels, gouache.
III. Sculpture: wood, stone, ceramic, metal.
IV. Ceramics.
V. Drawing and Graphic Art: all print techniques.
VI. Three-dimensional Design: weaving, stitchery, jewelry.
VII. Photography.

Further details may be obtained from Mrs. Kammeraad, 2961 Lake Drive, S.E., Grand Rapids, or Co-chairman Mrs. Robert Westerhoff, 2458 Maplewood, S.E., Grand Rapids.

ART EXHIBIT ENTRY BLANK

The following entry blank may be used for pre-registration to assist the committee in planning the show. Each exhibitor is allowed four entries in the entire exhibit.

Mail this blank to: Mrs. Lloyd A. Kammeraad
2961 Lake Drive S.E.
Grand Rapids, Michigan

I will have these entries in the following categories in the Doctor-Wife Art Exhibit:

Category

....No. of Entries...........

....No. of Entries...........

....No. of Entries...........

....No. of Entries...........

Name: ....

Address: ....

Woman's Auxiliary Convention Offers New Program Ideas

The Woman's Auxiliary to the Michigan State Medical Society will be meeting for their 41st Annual Convention, September 26 through September 28, in the Continental Room of the Pantlind Hotel in Grand Rapids.

Mrs. Henry Scovill, Ypsilanti, president of the Auxiliary, has announced that Mrs. Willis Dixon, Grand Rapids, is the general chairman in charge of the convention.

While the convention will conduct the regular business of the annual meeting, a new innovation has been introduced. Workshops will be held for the incoming officers and committee chairmen of the county auxiliaries to help those women who have accepted responsibilities in their local areas. County presidents will soon be receiving information as to the details of the workshops. Mrs. Scovill and the other officers urge the leaders of the county auxiliaries to attend.

Another innovation will be presented at this convention. County auxiliaries have been asked to present the past year's work of their society in the form of pictures of their outstanding activities. These pictures will be narrated by the presidents of the county auxiliaries and if "seeing is believing" this should prove most interesting and helpful.

The State Board of the Auxiliary will meet at a luncheon on Tuesday, September 26 and the Board of Directors will formally convene following this luncheon.

In addition to the business meetings and workshops, luncheons will be held Wednesday and Thursday. A theatrical sketch will be offered at the Wednesday luncheon and an outstanding speaker will be present at the Thursday luncheon.

Mrs. Lloyd A. Kammeraad, Grand Rapids, is chairman of the 1967 Art Show which again will be held in conjunction with the Annual Session of MSMS. Mrs. Kammeraad urges all physicians and physician wives to enter their personal art work in the exhibit. Prizes will be given for the best offerings in seven different categories.

Officers will be installed at the Thursday luncheon and a representative of the Woman's Auxiliary of the AMA will be the installing officer. The presidents and presidents-elect of the state auxiliaries of Illinois, Ohio, Indiana and Wisconsin have been invited to attend and will be formally presented at the convention.

MSMAS Convention Plans Progressing; Sept. 26-27-28

Mrs. Alta Greene, Battle Creek, president of t
Michigan State Medical Assistants Society, repor
the 18th annual convention of MSMAS will
held at the Morton House in Grand Rapids, Se
tember 26 through September 28.

Mrs. Dorothy Warner, Kalamazoo, first vic
president, is chairman of the convention and Mi
Phyllis Marquardt, also of Kalamazoo, is t
chairman of the Program Committee.

Registration, a hospitality hour and campaig
parties will be held from 6:00 to 10:00 p.m.
Tuesday, September 26.

The MSMAS House of Delegates will formal
convene at 8:00 AM, September 27, according
Mrs. Dorothy Brandis of Lansing, who is t
Speaker. All delegates should be present at th
time as none will be seated after the formal ope
ing of the House.

"Many outstanding speakers have been asked
participate in the convention. The final progra
will be announced as soon as plans are finalized
Miss Marquardt explains.

The banquet will be held on Wednesday ev
ning, September 27 with Mrs. Greene as chairma
In addition to a speaker, "The Medical Assista
of the Year" will be given her award. The me
cal assistant now holding this honor is Mrs. Pa
ine Moore of Bay City. This is a much soug
after award and each county society will be tryi
hard to get their nominee elected.

Awards will also be made to the county socie
making the biggest increase in membership duri
the past year, and to the county society having t
most outstanding county bulletin, according to t
judges. Mrs. Betty Attaway of Flint, is the Awar
Chairman.

New officers will be installed at the luncheon
Thursday, September 28. Mrs. Warner is hostess
this luncheon and the "Past President's Awar
given annually by Michigan Blue Shield, will
presented by John Verbiest of that organization.

All medical assistants, whether or not they a
members, are cordially invited to attend.

Council Reaffirms House Definition Of a Specialist

The MSMS Council, at its May meeting, approved two recommendations of the Ad Hoc Committee dealing with Resolution No. 22 approved by the 1966 House of Delegates to define a speialist.

The Committee recommendations were:

- "That The Council reaffirm its belief that the 1966 House of Delegates definition of a specialist is a practical and reasonable definition";
- "That The Council give greater dissemination to the fact that the federal Department of Health, Education and Welfare requires specialty designation; and the most fair and reasonable criteria can and properly should be made by physicians."

The Council concurred in both recommendaions.

In order that MSMS members become acquaintd with this definition, and in compliance with he two recommendations printed above, it is important that background information be provided.

As a result of the request of two county medical societies that the 1966 Resolution 22 regarding he need for defining a specialist be rescinded, The Council appointed an Ad Hoc Committee to study Resolution 22. This Ad Hoc Committee was chaired by Ross V. Taylor, M.D., and met on May 17, 1967. The Committee also included Harold F. Falls, M.D.; Brooker L. Masters, M.D.; . Carl Stander, M.D., and J. J. Lightbody, M.D. The informational material reviewed at the Committee meeting was:

1) Letter to Michigan Medical Service, September 9, 1966, from Arthur Hess;
2) HEW intermediary letter No. 90, July 20, 1966;
3) MSMS Staff Report (February 28, 1967) — Determination of Reasonable Charges by MMS for physician payment under Title XVIII-B.

Also invited to this meeting were: William Hines and William Stevenson, Michigan Medical ervice staff, to provide such information and to nswer such questions as may arise for the proper djudication of this issue. They explained that Blue Shield physician records always have contained a specialty coding (by physician self-designation) but these are now being updated to make records more accurate. The MMS representatives stated that the fiscal intermediary *was required* to code physicians according to specialty, but the physician will not be identified. It was also stated that MMS does not intend to use specialty designations to do more than reflect existing charge patterns of generalists and specialists, variations in services rendered, as well as variations in fees in different localities. Out of the development of physician profiles will come a "prevailing charge" in localities for both specialist and generalists, and will reflect the variations in practice and services, against which individual charges will be tested as to being "fair and reasonable." It was further stated that MMS feels that the Michigan State Medical Society had adoptable criteria for the designation of specialists that would satisfy the Social Security Administration. Failing to have done so might very well have given the Social Security Administration the opportunity to create its own definition.

In order that every member of MSMS be completely and fully aware of the delineation between GP's and specialists that was adopted by the 1966 House of Delegates and subsequently reaffirmed by the Council at its meeting in May, printed below is the complete definition:

Definition of Specialist

Whereas, Title XVIII and Title XIX of Public Law 89-97 does not clearly state a differentiation between generalist and specialist, and

Whereas, it would be expedient for the House of Delegates rather than the federal government to make such a distinction, therefore be it

RESOLVED: That the House of Delegates adopt the following definition of a specialist:

A specialist shall be a physician

1) certified by the appropriate specialty board, approved by the Advisory Board for Medical Specialties and by the American Medical Association Council on Medical Education, or
2) practicing as a specialist not possessing a specialty board certificate but
    a) has completed an approved residency in the specialty or has been graduated from medical school before 1945, and
    b) has had at least four years experience in a given specialty (including the recognized residency), and
    c) has at least 60 percent of his practice devoted to a given specialty, and
    d) is recognized as a specialist by the staff of the hospital in which he practices provided it is an accredited hospital.

MMS Board Reports New Blue Shield Concepts Emerging

SPECIAL RELEASE
FROM MICHIGAN BLUE SHIELD
TO MICHIGAN MEDICINE

Seven emerging characteristics have been approved by the Michigan Blue Shield Board of Directors for any revised program provided by Blue Shield.

Last year, a Blue Shield Board Ad Hoc Committee to Evaluate Factors Affecting Blue Shield was named. The primary area of analysis considered by the committee and Blue Shield management involved program benefits.

Major recommendations will be forthcoming shortly. The in-depth analysis includes field research activity, consultations with medical officials, as well as consumer representatives.

In a recent action, the Blue Shield Board approved certain emerging characteristics which the Ad Hos Committee felt should be part of any revised program provided by Blue Shield of Michigan.

The application of these characteristics to specific program design is now in process:

1. Blue Shield should take a position of leadership in developing new programs and not wait for the customer to suggest programs.
2. Blue Shield must move into benefit areas now uncovered and develop a comprehensive program based on needs, administrative feasibility and ability to deliver.
3. Total physician participation is a must in new programs, requiring meaningful commitment and equity to both the physician and subscriber.
4. Income as a factor in determining benefit eligibility is no longer feasible.
5. Physician reimbursement on the basis of fixed fee schedules is no longer feasible, and new payment mechanisms must be developed to reflect variation in charge patterns.
6. All new programs should also include meaningful utilization review and control mechanisms.
7. New programs must be developed which lend themselves to national uniform delivery to meet the needs of large national customers.

INVITES ATHLETIC TRAINERS

Team physicians and school trainers may obtain a copy of the program for the Athletic Training School, August 23-24-25 at Ferris State College, by writing to the Ferris trainer, A. G. Edwards, at Big Rapids.

mediscene

The Publication Committee is eager to list all major upcoming Medical events each month in Mediscene. All physicians are invited to help keep the list up-to-date and complete. It is hoped, too, that Mediscene will help sponsoring groups avoid conflicting events as much as possible.

July 15-16 — Upper Peninsula Seminar for Michigan State Medical Assistants, Marquette

July 27-28 — Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City

Sept. 18-22 — Workshop for Operating Room Nurses and Head Supervisors, Kellogg Center, East Lansing

Sept. 26-28 — MSMS Woman's Auxiliary, Pantlind

Sept. 27-29 — Seventh Annual Doctors and Wives Art Show, Civic Auditorium, Grand Rapids

Oct. 4-5 — Annual Convention, American Cancer Society, Michigan Division, Jack Tar Hotel, Lansing

Oct. 4-6 — Annual Meeting, Michigan Tuberculosis and Respiratory Disease Association, Pantlind Hotel, Grand Rapids

Oct. 5 — Annual Meeting, Michigan Thoracic Society, Pantlind Hotel, Grand Rapids

Oct. 10-13 — Annual Convention, Michigan Nurses Association, Jack Tar Hotel and Civic Center, Lansing

Nov. 26-29 — Conference on Genetics in Medicine,

Dec. 6-7 — Conference for Head Nurses, Kellogg Center, East Lansing

Michigan Newspapers Describe MD Concern

News releases are developed and processed by MSMS and sent regularly throughout the year to Michigan newspapers to provide good general information about health.

A recent story caught on well. It suggested five simple rules for people to keep their weight down. The article quoted C. Allen Payne, M.D., MSMS President, in his plea to Michigan residents.

Among the many headlines were these:

"Medics Promote Reducing Truths," Zeeland Record.

"Nothing Phony about Reducing Doctors' Way," Berrien County Record.

"Doctors Advise on How to Lose Weight," Jackson Blazer.

"Eating Less Is Called Best Way to Loss Pounds," Chelsea Standard.

"Doctors Offer Five Simple Rules for Reducing," Clare Sentinel.

about doctors and their friends

Harry A. Towsley, m.d., Chairman of the U-M Department of Postgraduate Medical Education, was installed at the 20th annual meeting as President of the Michigan United Fund. Doctor Towsley succeeds August Scholle, Michigan AFL-CIO President.

John M. Dorsey, Jr., m.d., Birmingham, recently was appointed by Governor Romney as a new member of the Michigan Youth Commission.

William Robinson Patterson, m.d., who is completing his third year of residency in orthopedics at The University of Michigan Hospital, has been named the U-M's outstanding resident of the year. Doctor Patterson received his medical degree from Ohio State University in 1960.

Charles L. Hudson, m.d., President of the American Medical Association was named Saginaw High School's distinguished alumnus for the current year. The award, the highest honor an alumnus can be given, was made at the school's 29th annual program.

Two Flint physicians have been recognized for their work with the handicapped employes of Flint's Goodwill Industries. Richard A. Antell, m.d., and Billie Lewis, m.d., were commended by the Genesee County Medical Society in connection with National Goodwill Industries Week.

Recently appointed director of the Mason County Medical Care Facility was Harry L. Clark, m.d., Ludington. A professor emeritus of Wayne State University where he taught bacteriology and clinical pathology for 30 years, Doctor Clark has been director of the laboratory at Paulina Stearns Hospital for the past 10 years.

Harold A. Ott, m.d., Royal Oak, is the new chief of Maternal Health, Bureau of Maternal and Child Health, at the Michigan Department of Public Health. Doctor Ott replaces Hermann A. Ziel, Jr., m.d., Lansing, who is now chief of the Bureau of Medical Care Administration in the Michigan Health Department.

Robert E. Rowe, m.d., Port Huron, has been named director of the Thumb District Health Department and the Thumb District Health Department will operate under the associated plan.

Hamilton E. Holmes, the first Negro male student in 1961 at the University of Georgia, is now an intern at Detroit General Hospital. After graduating with Phi Beta Kappa honors, he then integrated Emory University Medical School and completed medical school this past term.

Joseph Fischhoff, m.d., Detroit, Associate Professor of Psychiatry at Wayne State University, recently spoke at the Washington, D.C., meeting of the American Orthopsychiatric Association, on "A Clinical Study of Children Who Fail to Thrive: An Approach to Better Understanding and Appropriate Intervention."

John M. Wellman, m.d., Chairman of the Board of Michigan Blue Shield, and John C. McCabe, President, are serving as newly elected directors of Medical Indemnity of America (MIA) for 1967-68. MIA assists Blue Shield Plans in underwriting national accounts and groups with unusual benefit requirements.

The Soviet Union's Academy of Medical Sciences has presented awards for distinguished work in biological research to two University of Michigan physicians. The recipients are: Thomas Francis, Jr., m.d., Chairman of the Department of Epidemiology, and Fred M. Davenport, m.d., Professor of Epidemiology. Both men were awarded the Memorial Medal and Badge of the Gamaleya Institute of Epidemiology and Microbiology, Academy of Medical Sciences of the USSR.

The medical superintendent of Caro State Hospital, Willard W. Dickerson, m.d., retired May 1 after 18 years of service in the position. Doctor Dickerson had also served 10 years on the Hospital's Board of Directors.

Gerald A. O'Connor, M.D., right, U-M team physician, reviews some of the slides used in his talk about "Prevention and Treatment of Ankle Injuries" with four conference registrants. Left to right are R. W. Bullard, Jr., M.D., Clarkston; Kenneth Vanden Berg, M.D., Pontiac; A. A. Aardema, M.D., Muskegon; and David Millard, M.D., Paw Paw.

Team Doctors, Coaches, Trainers Jam Conference; Detroit in '68

Early plans are underway for the 1968 MSMS Conference on the Medical Aspects of High School Sports.

The Council has approved the recommendation of the MSMS Committee on the Medical Aspects of Organized Athletics to hold the 1968 event at Wayne State University Medical School. The 1968 program will help celebrate the Wayne State University Centennial, explains James A. Feurig, M.D., East Lansing, Chairman.

The conference last year, the first organized by MSMS and the University of Michigan, drew 60 physicians. It was decided to write high school coaches and trainers to future workshops.

The recent 1967 Conference at the University of Michigan drew 287 registrants with another 25-50 coming in to hear one or two speakers. The University of Michigan Department of Postgraduate Medical Education was the efficient co-sponsor.

Gerald A. O'Connor, M.D., director of the U-M sports medicine program, said the large registration "reflects the increasing recognition by high school coaches and trainers of the need for better supervision and medical treatment for the high school athlete." Doctor O'Connor was instrumental in arranging the conference program.

Speakers represented three Big 10 universities—Iowa, Michigan State, and Michigan—as well as the Detroit Lions professional team.

Conference subjects included knee injuries, the value of weight training and power lifting, genitourinary dysfunction and injuries, ankle injuries and foot problems, and ice therapy in injuries.

Charles E. Forsythe, director of the Michigan High School Athletic Association, discussed "Responsibility in Safeguarding the Health of the Athlete."

THE COACHES AND HIGH school team physicians were told they are "missing a good bet" if they are not using weight training to condition their athletes.

Dennis R. Burke, M.D., associate physician at The University of Michigan Health Service, sug-

Demonstrations in techniques of taping at the Conference held the interest of the coaches and trainers. Three trainers performed in areas of the big conference room. Here Millard Kelley, athletic trainer for the Detroit Lions, gives valuable pointers.

gested, "There is probably no better way for an athletic team to condition itself out of season than with a sensible weight training program combined with running and practicing the particular skills of the sport."

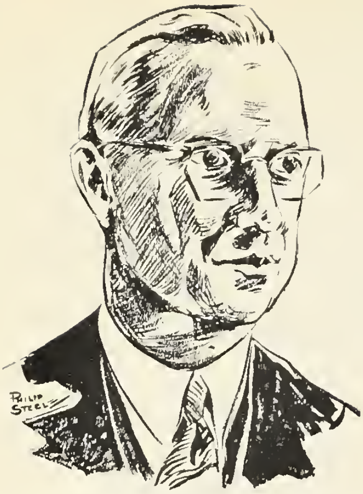
Doctor Burke discounted the idea that lifting weights results in muscleboundness of tightening. "This idea probably arose from the muscle beach boys who use 'pumping up' methods and overdevelop muscle groups in relation to their antogonists. Such practices have no useful place in weight training for sports."

Doctor Burke explained that weight lifting means competitive lifting using the three Olympic lifts — the clean and press, the clean and jerk, and the snatch, and that weight training refers to lifting weights to improve physical fitness and strength for a particular sport.

Robert Anderson, M.D., right, U-M Health Service, who spoke about "Genito-Urinary Dysfunction and Injuries," answers questions during a break. Seated, left to right, are LeRoy W. Juhnke, M.D., Mt. Pleasant, and R. W. Wilkins, M.D., Monroe.

Ideas for the 1968 Conference on Medical Aspects of High School Sports are being sought by Gerald Drake, M.D., Petoskey, at far left, from other physicians who attended the 1967 postgraduate program. Doctor Drake is a member of the MSMS Committee on the Medical Aspects of Organized Athletics, which is planning the 1968 event at Wayne State University in conjunction with the WSU Centennial observance.

More than 300 team physicians, coaches and trainers jammed the U-M medical center conference room for the recent 1967 MSMS Conference on Medical Aspects of High School Sports. Among those listening is Charles E. Forsythe, front at far left, Director of the Michigan High School Athletic Association, who spoke in the afternoon.



This artist's sketch of H. H. Cummings, M.D., appeared on the cover of the MSMS Journal in April, 1946 and described MSMS activities during the year of his presidency, 1942-43.

H. H. Cummings, M.D. Dies; Past President Of MSMS; PG Leader

Howard H. Cummings, M.D., beloved MSMS Past President and distinguished Ann Arbor physician, died June 22 at the age of 82.

"The university community, Ann Arbor, and the state of Michigan have lost a great physician with the passing of Doctor Cummings," said William N. Hubbard, M.D., Dean of the University of Michigan Medical School. "He contributed many advances to the two fields he served so well: the postgraduate education of physicians, and obstetrics and gynecology. As an educator, he was admired by all, and as a physician, he was dearly loved by his patients for his kindly manner and compassionate approach to human problems." Doctor Cummings had a distinguished career beginning with his graduation from the University of Michigan in 1910. After completing postgraduate study in obstetrics at Johns Hopkins University, he became an instructor of obstetrics and gynecology at the University of Michigan. Then, in rapid succession he became executive head of the University Health Service, began private practice in Ann Arbor, and served as Chief of Staff at St. Joseph Mercy Hospital.

In 1942 he became chairman of the Department of Postgraduate Medicine at the University. During World War I Doctor Cummings organized several ambulance units for field service with the French army.

Doctor Cummings was a founder of the American Academy of Obstetrics and Gynecology. In addition, he was associated with many medical organizations including the American College of Surgeons, the Central Association of Gynecologists and Obstetricians, the Galens Society, Alpha Omega Alpha, Phi Chi, and Sigma Xi. From 1947 to 1949 he was a member of the Michigan State Sanatorium Commission.

In addition to serving as president of the Michigan State Medical Society, Doctor Cummings was a councillor from 1933 to 1941, and was a Past President of the Washtenaw County Medical Society.

He was for 10 years chairman of the MSMS Committee on Postgraduate Medical Education, and at the time of his death he was serving as emeritus member and advisor to that committee.

Reflecting on his work in this area, Harry A. Towsley, M.D., Director of Postgraduate Medicine at the University of Michigan, noted that "Doctor Cummings furnished continued encouragement and sound advice to the area of postgraduate education of physicians, and his guidance and counsel will be sorely missed by the Department of Postgraduate Medicine at this University, and, in particular, by the Committee on Postgraduate Education of the State Medical Society. As a friend and a kindly, sympathetic and understanding physician, he will always be remembered."

APA Convention Hears Appeal for Quality Care for All

Physicians were urged to adapt themselves and their practices to the new programs of governmental medical care at the Annual Meeting of the American Psychiatric Association held recently in Detroit.

Harvey Tompkins, M.D., New York, said in his presidential address that unless doctors demonstrate a national will to bring health care to all citizens, the medical profession's badly bruised public image will suffer further damage.

Doctor Tompkins pointed out that quality medical care as a right for all people cannot be achieved by the rugged individualism of the past. The government's presence in the health field cannot be avoided, he explained, but the impact may be minimized if physicians emphasize high quality care in treating the masses as well as in treating private patients.

Peter A. Martin, M.D., Detroit, was chairman of the local arrangements for the national APA convention in Detroit.

"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.

BAYER
ASPIRIN
FAST PAIN RELIEF
ORANGE FLAVORED
BAYER
ASPIRIN
CHILDREN

Petrini, President During 100th Year Of WSU Med Alumni

(A photo of the outgoing and incoming presidents appeared in the June News Extra of Michigan Medicine.)

Mario Petrini, M.D., Detroit, will have the distinction of presiding at the Centennial meeting of the Wayne State University School of Medicine Alumni Association. He was installed as president for 1967-68 at the recent 99th annual meeting at the Sheraton-Cadillac Hotel.

Chosen as president-elect for 1968-69 was James Aiuto, M.D., Grosse Pointe, and Robert Allaben, M.D., Detroit, was named secretary. Warren O. Nickel, M.D., Dearborn, will continue as treasurer.

Wayne State University will observe its Centennial during the 1967-68 school year and the medical school plays a major role in the historical observance.

There were many other highlights of the 1967 Alumni Clinic Day and Reunion, May 17.

C. Jackson France, M.D., Detroit, a 1942 graduate of the School of Medicine, who is presently associate professor of clinical surgery at Wayne, received a Distinguished Service Citation because of his outstanding contributions to the medical profession.

Named to Honorary Membership in the Alumni Association were Alfred H. Whittaker, M.D., of Detroit, and Governor George Romney.

Arnold R. Axelrod, M.D., a Wayne State School of Medicine graduate, delivered one of the major papers in the afternoon called "The Inscrutable Red Cell," in which he described how the red cell has far outstripped its meager morphological beginnings — in the early 20th century, two unusual shapes of red cells were described and related to anemia, spherocytes and sickled cells.

Today, Dr. Axelrod observed, much more has been learned but "there is still much unknown, much to be learned. I would like today to briefly travel some of these investigational paths with you."

Other speakers at the scientific session were Eberhard F. Mammen, M.D., and Tommy Evans, M.D., both from Wayne State; Richard C. Schneider, M.D. and Paul W. Gikas, M.D., both from the University of Michigan; and John G. Gorman, M.D., blood bank director at the Presbyterian Hospital, New York.

Frank B. Bicknell, M.D., center, President of the Wayne County Medical Society for 1967-68, describes an idea to James C. Danforth, M.D., left, and W. C. C. Cole, Jr., right. Doctor Cole recently was elected WCMS secretary and Doctor Danforth was chosen as President-Elect to be installed in May, 1968 to succeed Doctor Bicknell. Doctor Bicknell succeeded Brock E. Brush, M.D.

New Award at Midland To Honor Towsley

An award to honor Harry A. Towsley, M.D., Ann Arbor, has been announced by his five daughters. It consists of a fund to endow an award of at least $1,000 annually to the outstanding Midland Hospital intern each year.

Dr. Towsley, a native Midlander, is Professor of Pediatrics and Communicable Diseases and Director of the Department of Postgraduate Medicine at the University of Michigan Medical Center in Ann Arbor. The award is founded as a tribute to his many years of dedicated devotion to the continued upgrading of graduate and postgraduate medical education.

It is anticipated that the first annual "Dr. Harry A. Towsley Award" will be granted in June of 1968.

Announcement of the award is made by his daughters, Mrs. John E. Riecker of Midland, Mrs. James C. Riecker of Ann Arbor, Mrs. Douglas W. Inglish, Jr., of Washington, D.C., Mrs. John R. Poteat of Haverford, Pennsylvania and Miss Grace Lynn Towsley of Boulder, Colorado.

MHA BACKS RESEARCH

"Cardiovascular Changes in Shock and Trauma" is a continuing research project to which the Michigan Heart Association recently contributed $11,436. A portion of $221,000 given to Wayne State University for heart research, the grant is directed by Robert F. Wilson, M.D., Birmingham, WSU Assistant Professor of Surgery.

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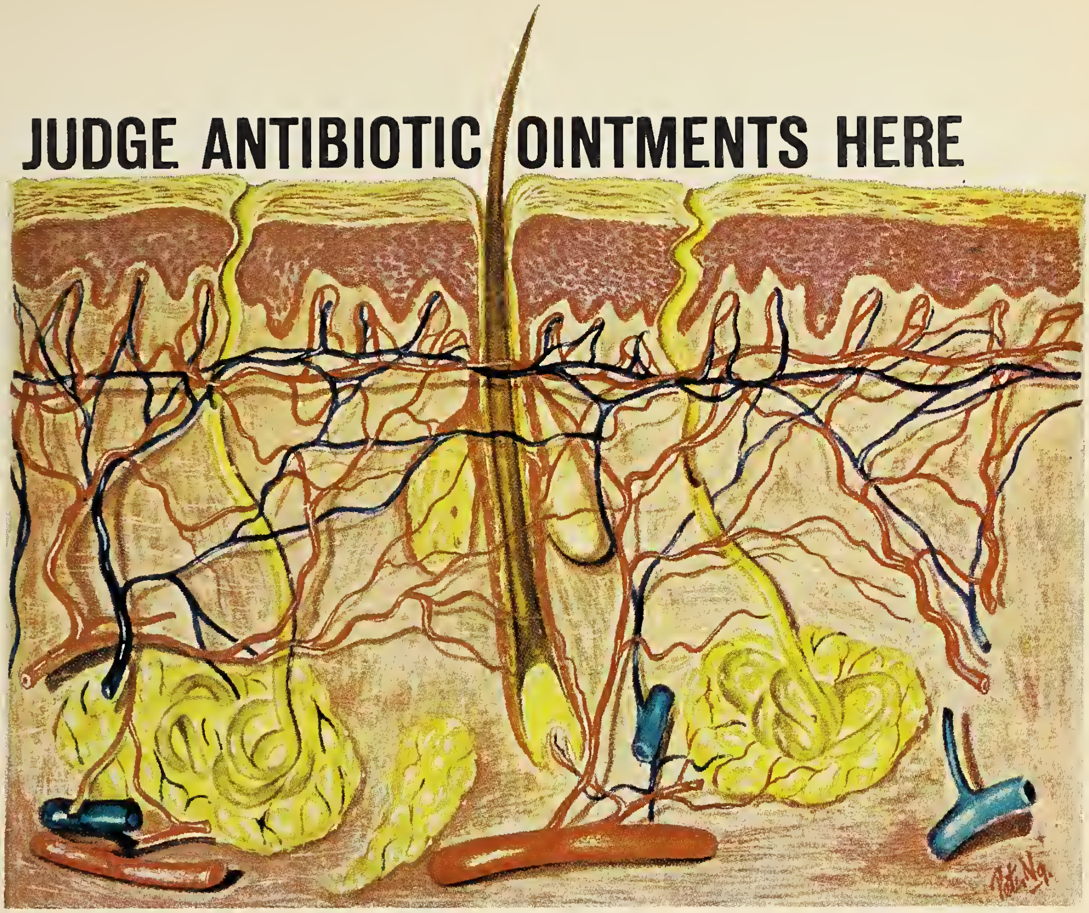

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.
Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

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POLYMYXIN B-BACITRACIN-NEOMYCIN
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Why these 7 patients with moderate to severe anxiety may respond better to Mellaril

1. The agitated patient.

Anxiety—particularly that beyond th range of minor tranquilizers—frequently is expressed as gross moto restlessness, fidgetiness and purposeless movements, and may erupt int aggressive behavior. Mellaril is almost a specific for those patient whose anxiety follows such a pattern

. The psychosomatic patient.

he family physician is rarely given
e diagnostic luxury of a classic,
xtbook "anxiety state." Most often
e must probe for anxiety masked by
functional disorder—or which exac-
rbates a somatic problem. Double-
lind evaluations have demonstrated
at Mellaril can be a significant ad-
nct in the treatment of such patients.

. The patient under
ituational stress.

ellaril helps the patient deal with
resses of everyday life. Nonhabitu-
ing, it can be given for extended pe-
ods of time. It does not "separate"
e patient from practical problems
d pressures, does not induce eupho-
a or a fuzziness which can compro-
mise the ability to cope with realities. Rather, it helps the patient move more competently in his daily world by eliminating useless tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.

4. The menopausal patient.

The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.

5. The previously hospitalized psychiatric patient.

Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.

6. The agitated geriatric.

Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.

7. The constantly returning patient.

The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.
Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.
Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.
Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril®
(thioridazine)

SANDOZ

Bartholin's gland
Periurethral glands
Cervical glands
Flagyl®.....
brand of
metronidazole
Seminal vesicles
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Prostate gland

Destroys Trichomonads Wherever They Are

Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

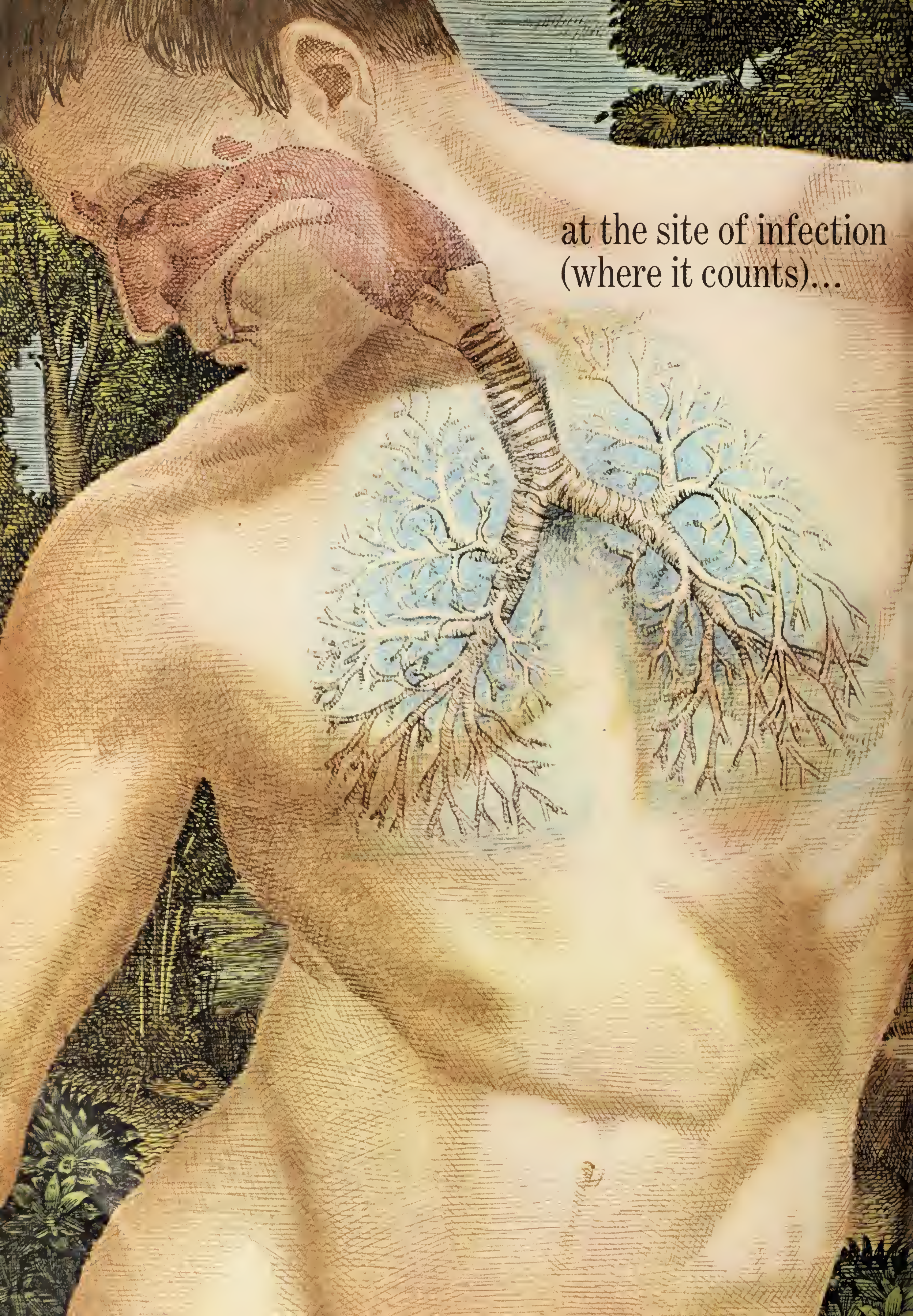
Dosage and Administration—In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.
In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

Contraindications—Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed...Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

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Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared
be definitely related to use of the drug, laboratory findings we
characterized by increased direct-reacting bilirubin, elevat
alkaline phosphatase levels, negative or weakly positive cephal
flocculation and thymol turbidity tests, elevated serum glutam
oxalacetic transaminase levels, peripheral eosinophilia, and no
mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has n
been reported in other patients taking prolonged courses of t
medication. Patients with chronic infection have been given 1
to 2 Gm. of the drug daily for periods of two to six months, a
patients with rheumatic fever have taken prophylactic doses
0.5 Gm. daily for two years without difficulty. In one group
144 patients who received the drug daily for two years, no jau
dice was noted. It was of interest that members of six of the
patients' families, who were not taking the drug, had episod
of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels we
determined in a group of fifty-four adults and children who to
250 mg. of Ilosone daily for an average of sixteen months
rheumatic fever prophylaxis. The results were compared wi
those of a similar group of forty-four patients who received pe
icillin. There were no cases of jaundice in either group. Elevati
of SGPT and serum alkaline phosphatase levels during the cour
of treatment was observed in one patient treated with Iloso
and in two patients treated with penicillin. Seven other patien
in the group receiving Ilosone and four others in the penicill
group showed elevations in one of the tests at some time duri
administration of the drugs.

Very satisfactory therapeutic results, without toxicity, we
reported in 102 pediatric patients who received short-term (te
day) courses of Ilosone in the treatment of streptococcus inf
tions. Results of liver function tests in these patients we
comparable to those in a similar control group who had receiv
penicillin.

Gastro-intestinal disturbances not associated with hepatic
fects are observed in a small proportion of individuals as a resu
of a local stimulating effect of the medication on the alimenta
tract; however, the normal intestinal gram-negative bacteri
flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the u
of erythromycin, there have been occasional reports of urticar
skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for O
Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of bo
weight, the usual dosage is 5 mg. per pound every six hours; f
children twenty-five to fifty pounds, 125 mg. every six hou
(Tablets Ilosone Chewable should be chewed or crushed a
swallowed with water.)

For adults and for children over fifty pounds, the usual dosa
of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromyc
therapy should be considered.

In the treatment of syphilis, the recommended total dosage
20 to 30 Gm. given in divided doses for a period of ten to fifte
days. Close follow-up of the patient is necessary since erythr
mycin drugs have not had adequate evaluation in all stages
syphilis. Examinations of spinal fluid are recommended as pa
of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days a
recommended. In the treatment of gonorrhea, patients with
suspected lesion of syphilis should have a dark-field examinati
before receiving antibiotics, and monthly serologic tests shou
be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 m
(equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivale
to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packag

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivale
to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packag

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-si
packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base
in bottles of 50. [03276

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 19
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 19
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

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700

Engelke Honored; Hanlon Installed As MPHA President

The 1967 Distinguished Service Award by the Michigan Public Health Association was presented at the recent MPHA Convention to Otto K. Engelke, M.D., Ann Arbor.

He was cited for his many contributions to medicine and health, including service as president in the past of the MPHA, MSMS, Michigan Health Council, Michigan Health Officers Association, and the Washtenaw County Medical Society. He has been director of the Washtenaw County Health Department since 1941.

Also honored at the Grand Rapids convention with a special award was Adelia M. Beenwkes, recently retired U-M professor of public health nutrition.

As the new president for 1967-68, John J. Hanlon, Detroit, presided at the Conference Dinner. WSU Dean Ernest Gardner, M.D., gave the dinner address.

The retiring president was Howard H. Mehaffey, D.D.S., Lansing.

Many physicians participated in the program. The Convention program listed Robert Locey, M.D., St. Joseph; James Wharton, M.D., Kenneth R. Wilcox, M.D., Lansing; Winston Protho, M.D., Grand Rapids; George P. Sweda, M.D., Detroit; Albert E. Heustis, M.D., Lansing; Chester A. E. Lund, M.D.; and Richard L. Wenzel, M.D., Ann Arbor.

Delgado of Yale Coming to Detroit For '68 Lecture

A Yale physiologist who has stopped a raging bull in midcharge, changed a loving monkey mother to a rejecting one, and turned a normally-reserved young woman into a flirt will deliver the 1968 Beaumont Lecture.

Jose' M. Delgado, professor of physiology at Yale, who has been doing controversial research into the effects of brain stimuation by tiny radio receptors, will come to Detroit for the WCMS lecture, April 1.

Conrad Lam, M.D., is chairman of the Wayne County Medical Society Beaumont Lecture Committee.

The 8-page reference folder about "Prescribing and Dispensing Narcotic Drugs" is offered to MSMS members. It may be removed easily from Michigan Medicine.

Seek Camp Midicha Applicants

Camp Midicha for diabetic children is holding two 10-day sessions near Oxford, July 16 - August 5. Boys and girls ages 8 through 16 are eligible for the program which provides individual medical and dietary supervision.

Applications can be obtained from Michigan Diabetes Association, 10737 W. McNichols Road, Detroit, Michigan, 48221: Telephone (313) 342-9333. Partial and full camperships are available to families who cannot afford the full cost. A printed brochure detailing the program is available on request.

Rowe Renamed President Of Diabetes Society

John B. Rowe, M.D., Flint, has been re-elected president of the Michigan Diabetes Association. The annual meeting in Grand Rapids also elected Miss Margaret Culley, Flint, as state chairman of the Lay Society.

Doctor Rowe said that the young diabetic, who has the most to gain from medical research, will be the main target of the MDA in the years to come. He revealed that serious consideration is being given to the establishment of a year-round activity center where youngsters could be taught proper diabetes management and where interns, nurses, dietitians, and other interested professionals could be trained to better assist diabetic youngsters, both physically and phychologically. The center would also serve the needs of the many adult diabetics in Michigan.

Also re-elected for a one-year term were Fred W. Whitehouse, M.D., Detroit, Vice-President; Gregory Donovan, Treasurer; and Mary M. Harrington, Secretary.

Frank S. Perkin, M.D., was elected to the position of Honorary Member of the Board of Directors.

Re-elected to the Board of Directors were the following doctors; John P. Harm, M.D., Detroit; John B. Bryan, M.D., Detroit; James J. Aiuto, M.D., Grosse Pointe; Nancy T. Caputo, M.D., Grosse Pointe, and Doctor Rowe.

Special awards for outstanding contributions to the Michigan Diabetes Association, a United Fund Service, were presented to Doctor Rowe, and seven other lay leaders.

Among those elected to the Board of Directors for a three-year term was George A. Lowrey, M.D., Ann Arbor.

The annual meeting guest speaker, Randall G. Sprague, M.D., of Rochester, Minn., Past President of the American Diabetes Association, stressed the importance of careful adherence to medication and diet.

The medical history for the next patient is reviewed by J. Leonidas Leach, M.D., in his Flint office, which serves now also as the "president's office" for the Michigan Academy of General Practice.

First of Race to Lead Academy

Flint Physician Stresses Need For General Practitioners in State

BY KIM CORTRIGHT
MSU JOURNALISM SENIOR

After 53 years of medical practice, J. Leonidas Leach, M.D., is remodeling his Flint office and stepping up his pace. He is far from slowing down as most men at 72 might do.

Doctor Leach's colleagues recently honored his personal dedication to man and medicine by electing him president of the Michigan Academy of General Practice.

During his years of practice Doctor Leach has seen great changes in every facet of life, especially in the field of medicine. He has seen the increase of the specialists.

AS SPOKESMAN NOW for the general practitioners of Michigan, Doctor Leach has both a personal and professional belief in the value of the non-specialized doctor.

"The family doctor is urgently needed. He is still the best man to treat general ailments, to safeguard the health of the whole family and to help advise the family members when they need specialists," said Doctor Leach.

"As general practitioners, we must remember that we are here to serve the general public. By acting as an effective link between the family and the world of medicine, we can increase the integrity of the medical profession." he added.

Doctor Leach is deeply concerned about people. "A doctor's got to love people. If he doesn't, he's in the wrong profession."

He continued, "Service has to be put above financial return. A man who loves people and works for their good, will be rewarded in many ways more important than money."

Doctor Leach often advises young men to go into medicine. Now that all colleges have opened their doors to Negroes, he sees unlimited opportunities for young Negroes interested in medicine. "The hopeful Negro physician must now do his part by being educationally, morally, and financially prepared for his medical training."

Medical schools have neglected the field of general practice too long, according to Doctor Leach. He advocates the establishment of a department of general practice in every hospital and medical school in the country.

His full life testifies to the fact that Doctor Leach is a "doer" as well as a thinker.

He was born in 1895 in Nashville, Tennessee, where he attended Meharry Medical College. After graduation he taught for a while at Meharry, then spent two years in France as a captain in the Army Medical Corps during World War I. In 1920 he came to Michigan and began his present practice in Flint.

His record of public service in Flint is extensive. He served on the Flint Welfare Committee for 25 years, and he pioneered an improved program of medical aid for the indigent by the creation of the Genesee County Welfare Clinic in 1959. He was the first Negro elected to the Board of Supervisors. He helped organize and raise $25,000 for the creation of the Flint Cultural College Center.

He organized the Flint chapters of the Knights of Pythias, the I.B.P.O.E., the N.A.A.C.P., and has been instrumental in finding positions for Negro policemen, nurses, and interns in Flint.

For 18 years Doctor Leach was a member of the national board of the N.A.A.C.P., and he has long been a member of the General Board of the African Methodist Episcopal Church. He is the present executive secretary of the Richard Allen Foundation.

He is medical examiner for Genesee County. Doctor Leach, long a leader on the MSMS Public Relations Committee, has been honored by Life Memberships to the AMA, MSMS, and the Genesee County Medical Society.

He loves his profession and he loves people. "How can you be concerned about people from a medical standpoint and not be concerned about them politically, economically, and morally?" he asks.

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viewpoints

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Physicians have many opportunities every day to explain the costs of good hospital and medical care.

Try this approach someday:

The next time a patient has an appendectomy, tell her that 25 different men and women cooperated as a health care team to make the operation successful.

Encourage your patient to tell her friends not only about the operation but also about these 25 people:

A five-man medical team, a surgery supervisor, two laboratory technicians, a pathologist, a radiologist, recovery room superintendent, floor nurse, X-ray technician, medical records clerk, central supply clerk, dietician, administration clerk, housekeeper, volunteer worker, orderly, pharmacist, chaplain, building engineer, telephone operator and cashier.

Rising medical care costs? Definitely, yes. But still a terrific bargain!

Quality Versus Price

BY F. P. RHOADES, M.D.
REPRINTED FROM DETROIT
MEDICAL NEWS

There is increasing concern in the minds of practicing physicians that the flood of directives promulgated by F.D.A. will lead to an irreversible decline in the quality of medical care. It is basic to good medical practice for the physician to have the freedom to prescribe the kind of treatment his training and experience has taught him is best for each individual patient's illness. In the course of this treatment it is essential that he be accorded the right to prescribe the exact therapeutic agent he has found to be most effective.

The F.D.A. is apparently determined to pursue a course of action that has as its ultimate goal the banning of any drug that has a demonstrable side-reaction that, in their opinion, is undesirable. At the same time the drug must be proved effective. This attempt to achieve both efficacy and complete safety in a drug is an unobtainable goal. It is axiomatic that if a drug is effective it also is capable of causing adverse reactions in some patients. All medical treatment is a calculated risk.

The steady pressure of various departments of government to insist on generic drugs with the plea that they are less expensive is false economy. Surveys have shown that the substitution of generic for brand name drugs would result in only minimal savings. Since we are dealing frequently with life or death situations a "cheap" drug may be more "expensive" than we are willing to pay. A brand-name drug contains that quality beyond price – the established reputation and honor of its maker.

Fortunately, the guidelines for implementation of the basic policy of H.E.W. that states "all medication should be purchased at the lowest cost available" has been modified. It now reads "grantees should be encouraged to purchase drugs under their nonproprietary or generic name consistent with such acceptable standards and with due regard for the professional prerogatives of physicians and pharmacists."

Unfortunately, this freedom of action for the physician and pharmacist is seriously threatened by a further directive. "Grantees should be encouraged to develop and disseminate information, such as formularies and other compendia, which will be of assistance to physicians and pharmacists in prescribing and dispensing the lowest-cost medications that meet acceptable standards of identity, strength, quality, purity, safety, and effectiveness."

Other recent actions of the F.D.A., such as arbitrary seizure of pharmaceutical products because it is alleged that advertising concerning them failed to carry "full disclosure" is destroying the confidence of the public in both the drug industry and physicians. The public will be left with the false impression that the product seized must be dangerous and that their physician is untrustworthy if he has prescribed this product for them.

Thus we are back where we started. It will take courage and constant vigilance to withstand the pressure exerted by an "official formulary." If we are to judge by the past such tactics result in the majority of prescriptions being for the "approved medication." Quality of medical care is certain to suffer.

Medically Indigent?

BY FRANK COLE, M.D., EDITOR
NEBRASKA MEDICAL JOURNAL

Well, when I get through paying for my groceries, and rent, and the car, and clothes, and vacations, there's not enough left for the doctor, so that makes me medically indigent, doesn't it?

The government says now, I don't even have to go through all that figuring.

If my income is below whatever they think is average, I'm medically indigent.

We just thought of a stunning retort to this kind of what is laughingly called thinking. If you paid your doctor first, you might be clothingly indigent, or vacationly indigent, or grocerally indigent.

But you can't be automobilely indigent; you have to pay for your automobile.

The philosophy of assuming that you pay your doctor last, and that below a certain income level you can't pay him at all is one we can neither understand nor embrace. But if there were ever any incentive for getting on, for saving, for preserving one's dignity, in short, for working, it has been stifled by the command that such thoughts are to be put away; that you do not need to work or save, that the government will take care of you if you are indigent; and that if you are indigent, stay indigent.

Especially medically indigent.

Have You Joined MDPAC?

BY VERNON V. BASS, M.D., SAGINAW
CHAIRMAN OF MDPAC

Membership is the life blood of MDPAC and AMPAC.

With a large, active membership, we live. If we lack it, we perish. If we have some members, but not enough, we suffer from a dangerous anemia. Members mean to the PAC movement not only health, but survival.

If you are not now a PAC member, this is an appeal to join.

Then, sign up your colleagues and their wives. Remind them that off-years are just as important as election years. Remind them that good government — whether at the national or state levels — demands continuity, vigilance, effort, and effectively concerted political action.

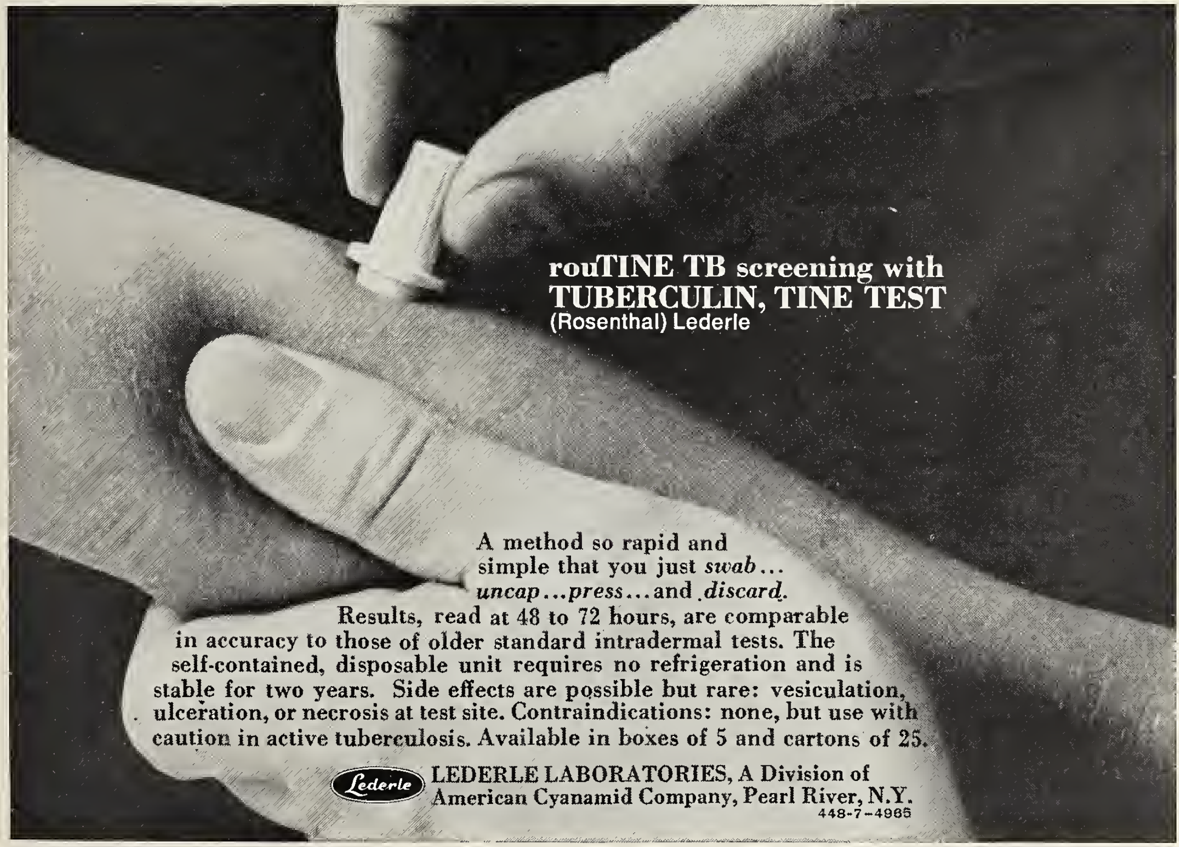
Membership dollars this year are essential if the PAC movement is to provide realistic support to next year's candidates. It counts most early, before finance committees have shifted into high gear, before budgets have been formulated, before radio, television, and billboard availabilities have been grabbed by the opposing candidates.

There is another good reason to have membership dollars now in the bank as 1968 rolls around: the primary campaigns.

Medicine's PAC movement is moving toward maturity. It has proven it can get results. It is acknowledged, by the leaders of both political parties, to be a political force of limitless potential.

Do your part by joining and by being an interested, active member.

MDPAC membership dues should be sent to Box 169, East Lansing.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(Rosenthal) Lederle

A method so rapid and simple that you just *swab*... *uncap*...*press*...and *discard*.

Results, read at 48 to 72 hours, are comparable in accuracy to those of older standard intradermal tests. The self-contained, disposable unit requires no refrigeration and is stable for two years. Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in boxes of 5 and cartons of 25.

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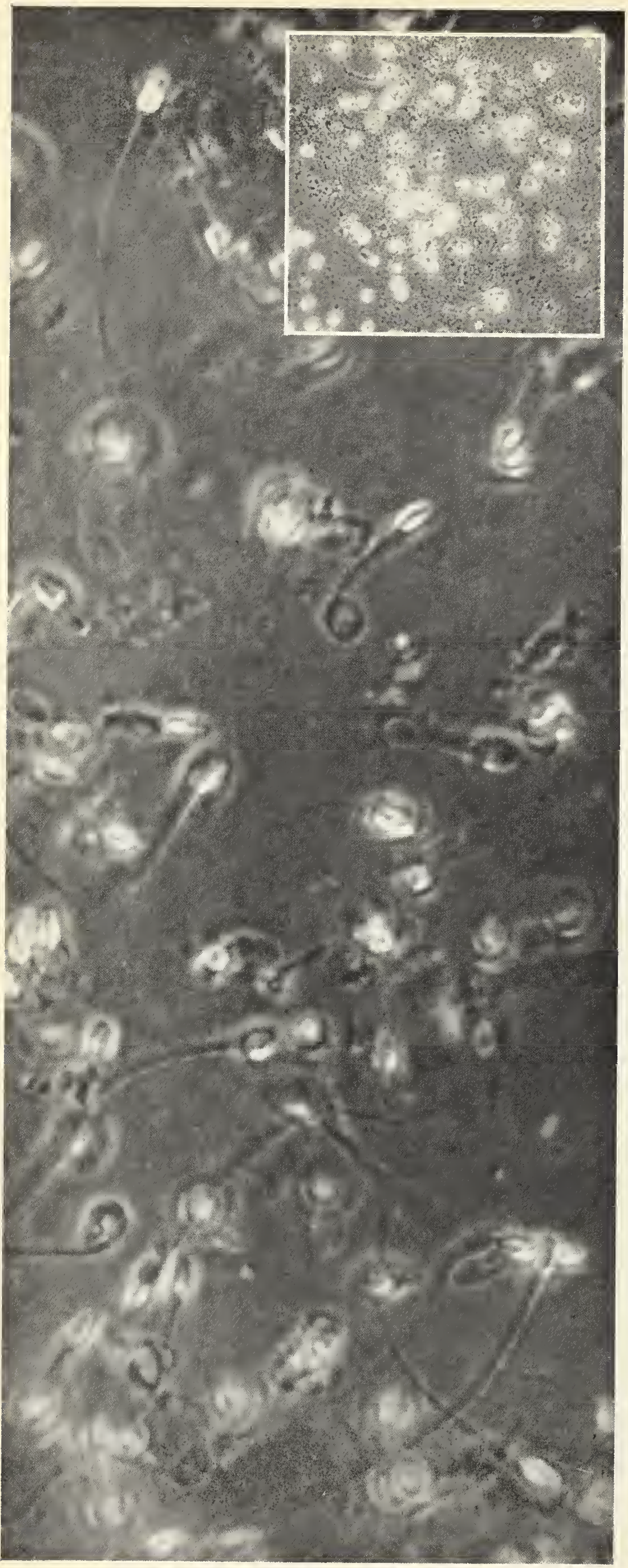


New view of an oral contracepti at work

Although suppression of ovulation rema
the primary mode of action of oral contr
ceptives, newer knowledge indicates that
products like Norinyl-1— a combination of
both low-dosage progestogen and estrog
for the full treatment cycle—may provid
multiple action that helps explain their u
excelled record of contraceptive effectiv
ness. This report explores the possible
secondary protective mechanisms offered
combined hormonal administration.

Accumulating evidence has indicated th
sparse, highly viscous cervical mucus ha
possible adverse effect on the motility an
survival of spermatozoa.

The estrogen-opposing progestational ing
dient of Norinyl-1 (norethindrone 1 mg. w
mestranol 0.05 mg.) changes the usual mi
cycle picture of a thin, watery cervical mu
The result—a built-in barrier that appears
inhibit sperm from reaching the ovum sh
one be released. The inset in the adjoinin
photograph shows immobile spermatozo
they appear in cervical mucus taken from
patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

ow the estrogen-opposing ction of Norinyl-1 creates ervical mucus that may be hostile o sperm penetration

ormally, estrogen activity during the fertile midcycle stimulates the production of a ofuse and watery cervical mucus that permits maximum sperm motility and omotes penetration.

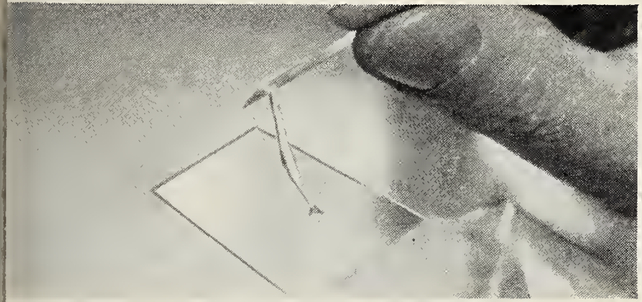
it what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, pposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus ecreases and its viscosity increases. This results in a sparse but thick mucus barrier at appears to diminish the vitality of the sperm and to impair its powers of penetration.

he role of viscous cervical mucus as a secondary action of Norinyl-1

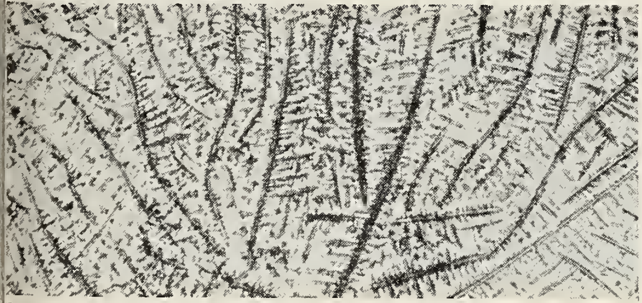
a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit. the opinion of this investigator, the effect on cervical mucus may be sufficient to event conception.

hen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

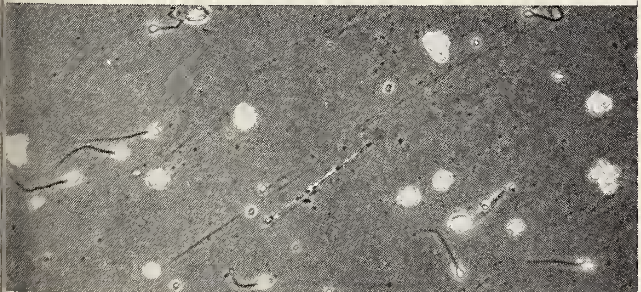
ormal cervical mucus at midcycle untreated patient known to permit sperm motility... romote sperm penetration.



ervical mucus is thin and watery with a stretchability pinnbarkeit) of 15 to 20 cm.

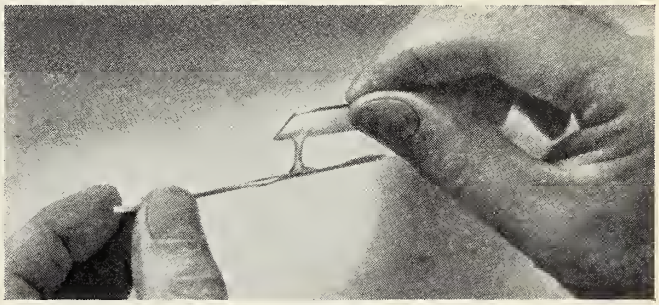


hin, watery mucus crystallizes into this well-defined, rnlike pattern within a minute.

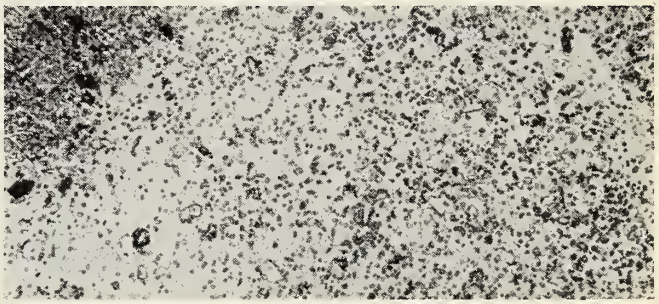


permatozoa appear healthy, are active nd freemoving.

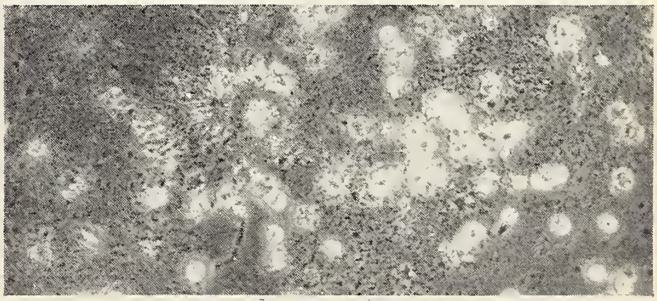
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

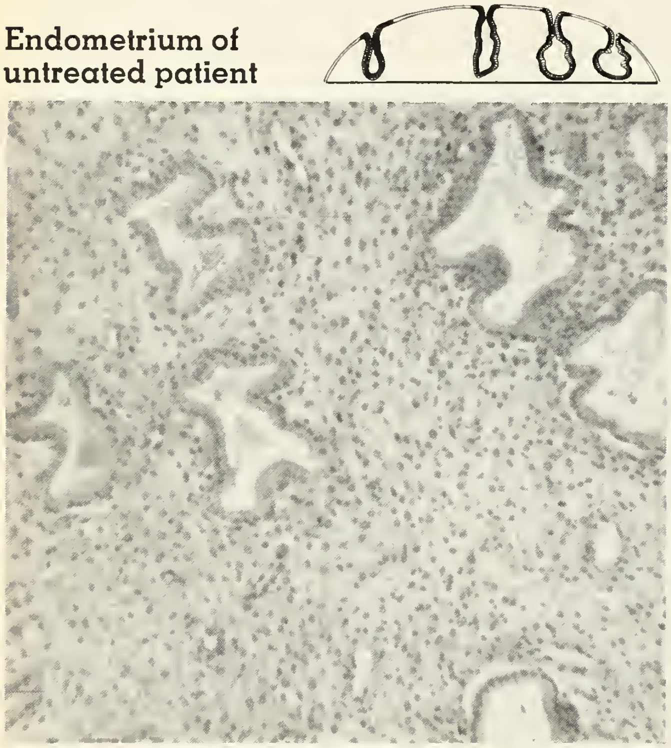


Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

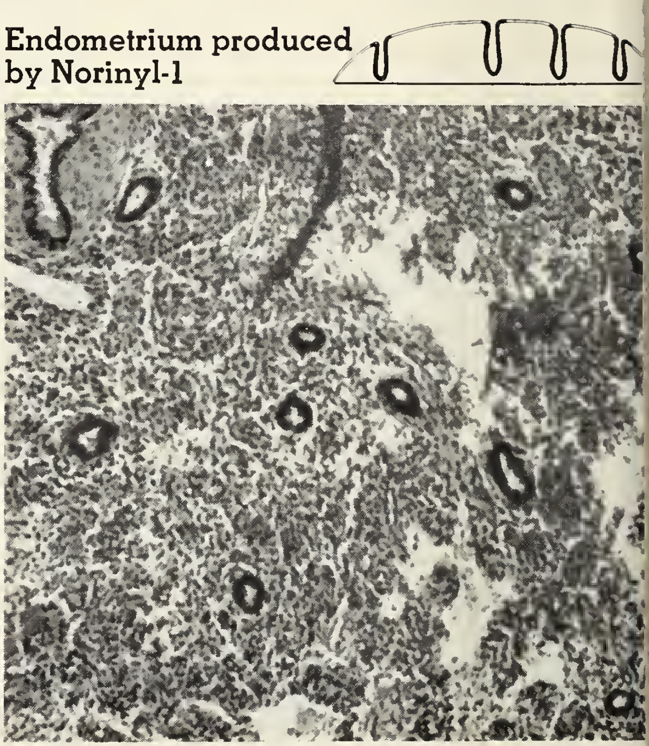
Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of untreated patient



Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1



When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new **Norinyl-1**® tablets

(norethindrone 1mg. c̄ mestranol 0.05mg.)

See last page for contraindications, precautions, side effects and dosage.

ffective fertility control
half the previous dosage

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the established
orethindrone/mestranol
ombination

wer cost

new
Norinyl®-1
(norethindrone 1mg. c̄ mestranol 0.05mg.) tablets

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

ESCRIBING INFORMATION

ntraindications: 1. Patients with thrombo-
ebitis or with a history of thrombophlebitis
pulmonary embolism. 2. Liver dysfunction or
ease. 3. Patients with known or suspected
cinoma of the breast or genital organs. 4. Un-
gnosed vaginal bleeding.

rnings: 1. Discontinue medication pending
mination if there is sudden partial or com-
te loss of vision or if there is a sudden onset
proptosis, diplopia, or migraine. If examina-
reveals papilledema or retinal vascular
ons, medication should be withdrawn. 2.
ce the safety of Norinyl-1 in pregnancy has
been demonstrated, it is recommended that
any patient who has missed two consecutive
iods, pregnancy should be ruled out before
tinuing the contraceptive regimen. If the pa-
t has not adhered to the prescribed schedule,
possibility of pregnancy should be consid-
d at the time of the first missed period. 3.
ectable amounts of the active ingredients in
l contraceptives have been identified in the
k of mothers receiving these drugs. The
nificance of this dose to the infant has not
n determined.

cautions: 1. The pretreatment physical exam-
tion should include special reference to
ast and pelvic organs, as well as a Papani-
aou smear. 2. Endocrine and possibly liver
ction tests may be affected by treatment
h Norinyl-1. Therefore, if such tests are ab-
mal in a patient taking Norinyl-1, it is recom-
nded that they be repeated after the drug
been withdrawn for 2 months. 3. Under the
uence of estrogen-progestogen preparations,
existing uterine fibroids may increase in
. 4. Because these agents may cause some
ree of fluid retention, conditions that may
influenced by this factor, such as epilepsy,
raine, asthma, cardiac, or renal dysfunc-
, require careful observation. 5. Although a
se and effect relationship has not been
ablished, Norinyl-1 should be used with cau-
in patients with a history of cerebrovascu-
accident. 6. In relation to breakthrough
eding, as in all cases of irregular bleeding
vaginam, nonfunctional causes should be
ne in mind. In cases of undiagnosed vaginal
eding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

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Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
Ephedrine HCl	16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

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MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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Abortion - A Complex Issue Today Calling For More Discussion

BY PETER HOHEISEL
OF MSMS STAFF

That the public wants to hear what physicians have to say about abortion is obvious. The Maternal Health Conference this past spring was the scene of many questions and much discussion about this sensitive issue.

This is a brief report on some of the medical and moral issues which the Conference raised.

No physician wants to find himself in a hypocritical position. As J. Robert Willson, M.D., Chairman of the Department of Obstetrics at the University of Michigan Medical School, pointed out: "Obstetricians recognize the fact that some women with serious emotional disturbances cannot be effective mothers and should not become pregnant, but it is difficult for us to accept this alone as an indication for therapeutical abortion. We feel quite comfortable, however, if a psychiatrist assures us that the patient may commit suicide if

HE FAMILY LIFE CYCLE

Lee B. Stevenson, M.D., Detroit (left), a member of the Maternal Health Committee of the Michigan State Medical Society, and Leon Israel, M.D., Philadelphia, study materials at the display of sex education aids at the MSMS Maternal and Perinatal Health and Welfare Conference in Flint. Doctor Israel was a featured speaker at the conference, his topic being, "The Role of the Physician in Family Life Education."

she is not aborted. This makes termination 'legal' because pregnancy endangers the 'life' of the patient.

"The hospital committee approves the operation, and we proceed, completely ignoring the fact that the suicide rate for pregnant women is much less than that for all women between the ages of 14 and 50. Pregnant women, even those who threaten to do so, do not often kill themselves. If we can conclude that there is little risk of suicide during pregnancy, even in women with emotional disorders, why do we terminate the pregnancy with this as the reason? We do so because of socio-economic factors, because we don't think that a child raised by psychotic parents stands a chance of developing normally or because so-called 'legal' abortion is much easier than caring for an emotionally disturbed patient during the entire pregnancy, labor, and puerperium. We accept psychiatric indications for abortion, but we deny that such procedures can be done legally."

Before you criticize a man you must try to evaluate his position. For the moralist to shout at the physician who wants a change in abortion laws, "Doctors should save life, not destroy it," or to be unaware of the tragedies physicians face when women who have been butchered by amateur abortionists come to them, or to ignore the paradoxical position into which our present laws put the doctor, as outlined above by Doctor Willson, is to have a mind closed to the exciting problem.

Likewise, for the physician to treat the abortion question as if it were purely a medical question answerable by surveys, statistics, and science, would be just as short-sighted as the recalcitrant moralist who does not understand the ambiguous situation physicians face under our present laws.

It is not irrelevant to determine when the fetus becomes a human being with the right to life, liberty, and the pursuit of happiness. If the fetus is not a person, on what grounds should any woman who wants an abortion, provided it is not harmful to her, be denied one? On the other hand, if the fetus is a person, on what grounds can someone decide to take its life? Is the fetus simply an extension of the mother, totally subject to her decisions and the decisions of others, or is the fetus a human person whose rights are to be cherished as much as any other person's?

To advocate legalized abortion, terminating a pregnancy even when it does not present a direct threat to the woman's life, without deciding when the fetus becomes a human being is to avoid a serious question. On the other hand, to condemn legalized abortion, without realizing how many medically inadequate abortions are taking place no matter what laws or moral pronouncements are made, and without realizing the hypocritical

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position in which our present laws place the physician, is to avoid an equally serious question. (Some interesting and sobering statistics are presented by L. B. Stevenson, "Maternal Death and Abortion, Michigan 1955-1964," *Michigan Medicine,* March 1967, pp. 287-291.)

That these profound questions were discussed at the Conference in Flint is a tribute to the Michigan State Medical Society and the work of William Jack, M.D., Grand Rapids, chairman of the Committee on Maternal Health.

Physicians are accepting their responsibility to enter public discussion of this matter. Doctor Willson summarized well the physicians' responsibilities: "Abortion is a medical problem, and the responsibilities of the physician, particularly obstetricians-gynecologists, are:

"1. To acquaint legislators, clergymen, public officials, lay citizens, and their fellow physicians with the facts concerning present abortion practices.

"2. To stimulate legislators to examine abortion laws and to prepare new ones which would conform to modern medical practices. Modern laws would permit responsible physicians to perform necessary abortions in reputable hospitals, legally and without the subterfuge which is now necessary.

"3. To act as consultants to the legislators in their revision of the statutes.

"4. To develop and support educational programs on sex education, contraception, and family living as important aspects of general health care. Hopefully, more complete and accurate understanding of reproduction in general will reduce the need for both therapeutic and illegal abortion."

Ingham Cities Youths; Gets Scout Charter

The Ingham County Medical Society has once again given awards to winners of the Youth Talent Show's Junior Science Division. Three $25 awards were presented to Edmond A. Cheeney, St. Johns; Sharon K. Lambeth, Holt, and Gary E. Gallick, Lansing, for their outstanding medical exhibits.

The awards were given at a program chartering the Society's new Scout Explorer Post. The Explorer charter was presented to Donald R. McCorvie, M.D., Williamston, Charles C. West, M.D., and Joseph R. Cipparone, M.D., both of Lansing. The Explorer Post is sponsored by the Ingham County Medical Society.

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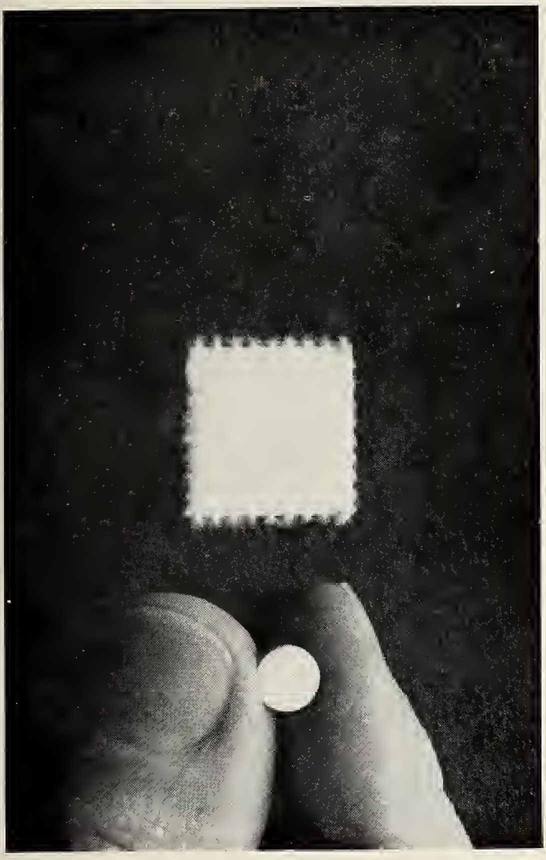

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U-M Host in Fall For World Conclave On Leukemia

As part of its sesquicentennial celebration, the University of Michigan will sponsor an International Conference on Leukemia-Lymphoma in Ann Arbor, October 9-13, 1967.

Emphasis of the conference will be on these diseases as they relate to man. Animal data, however, will be included when it is helpful.

Depth study of the leukemia-lymphomas will focus on their etiology and epidemiology; the biochemical aspects of these disorders as well as some statistics of recent trends will also be included. The final portion of the program will discuss current treatment and results.

Speakers will be as follows: Alan C. Aisenberg and William S. Beck, Massachusetts General Hospital; Gould A. Andrews, Oak Ridge Inst. for Nuclear Studies; John W. Athens, University of Utah; Ray W. Bryan, Albert J. Dalton, Mary A. Fink, Robert W. Miller, and Gordon C. Zubrod, all from U.S. Public Health Service; Joseph H. Burchenal, Sloan-Kettering Inst.; Denis Burkitt, London, England; William Dameshek, Mount Sinai Hosp. NYC; Leon Dmochowski, M.D., Anderson Hospital, Houston; Eugene P. Frenkel, Southwestern Medical School, Dallas; Robert A. Good, University of Minnesota; Frederick Gunz, Christchurch, New Zealand; Clifford W. Gurney, Rutgers Medical School.

Also speaking will be Isadore Lampe, Muriel C. Meyers, and William H. Murphy, all from U of M; F. G. J. Hayhoe, Cambridge, England; David A. Karnofsky, Sloan-Kettering Inst., NYC; Peter Nowell, University of Pennsylvania; Van R. Potter, University of Wisconsin; Saul A. Rosenberg, Stanford; Wayne R. Rundles, Duke; Robert S. Schwarz, Tufts; Arthur C. Upton, Oak Ridge National Laboratory; and Wolf Zuelzer, Children's Hospital, Detroit.

POVERTY IN THE U.S.A.

Written by J. Stouder Sweet. FL 398. Can the United States do away with poverty? Yes, is the answer in this pamphlet based on the study *Poverty Amid Affluence,* sponsored by the Twentieth Century Fund. The author discusses who the poor are, where and how they live, estimates the cost for poverty to be completely eradicated. Copies available from: Public Affairs Committee, Inc., 381 Park Avenue South, New York, New York 10016. $0.25 each, lower in quantity.

Physicians, Saint John Hospital, Detroit, Sponsor Lively Medical Careers Explorer Post

(Note: Almost every day, MSMS receives one or more requests for the AMA Horizons Unlimited *career handbook. A request from Saint John Hospital, Detroit, led to the following letter explaining the Medical Careers Explorer Post at that hospital. It is printed here as a guide for physicians and county medical societies who might wish to establish such Explorer units.)*

BY PANFILO C. DiLORETO, M.D.
DETROIT

May I explain how we are using the AMA career handbook entitled "Horizons Unlimited" They are being used in conjunction with the Medical Careers Explorer Post No. 522, at St. John Hospital, Detroit.

I am taking the opportunity to describe the functions of this organization because there is certainly a need for others in our state. Assistance should come from both the state and local county medical society in establishing more programs of this type.

In 1962, with the approval of the administration of St. John Hospital and the support of the Detroit area Council of the Boy Scouts of America, we organized Explorer Post No. 522, for those high school individuals who were interested in pursuing some field of medicine as a career. This organization has been functioning continuously since then. It has received enthusiastic support from the high school students and also from the teachers and counselors in the high schools in the east side of Detroit. We have been attempting to give information regarding various vocations to all young individuals who are interested in the medical and para-medical fields as a livelihood.

We have covered a wide variety of subjects, including for example, veterinary medicine and the field of mortuary science as careers.

The organization is composed of young high school students who elect their own officers and conduct the meetings in a democratic fashion similar to any adult organization. Meetings are held twice a month during the school year. During the past two years Lawrence Kelly, M.D., has assisted me in this program as the Post Advisor. I remain the Institutional Representative for liaison with the administration of the hospital. The expenses for conducting this program are underwritten by St. John Hospital.

Initially, because this was a Boy Scout organization, only boys were admitted. However, because of the demand and because the Girl Scout organization had no equivalent program to offer, in the last two years this post has accepted young high school girls as an auxiliary with their own officers.

At the present time the attendance at these meetings averages in the neighborhood of 60 to 80 high school students in addition to some teachers and counselors. On certain nights, depending on the subject matter to be discussed, the attendance has reached almost 200 individuals. Some high schools in the area have become particularly interested in our program and provide a school bus to transport their students to the hospital for these meetings.

The Grosse Pointe Kiwanis Club has taken an active interest in our Medical Careers Post. The

(Continued on Page 906)

in chronic illness

B and C vitamins are part of therapy: An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, are formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.

STRESSCAPS

Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York Lederle

628-6—3614

SAINT JOHN HOSPITAL/Continued

club donates an engraved plaque which is presented to each speaker.

Each meeting has a speaker. We attempt to provide a movie whenever possible. We arrange tours of the appropriate departments of the hospital that are concerned with the subject of the meeting. Some meetings have demonstrations. At most meetings some literature, that we attempt to obtain beforehand, is passed out to those who are interested. We have also used this medium to provide additional education for the high school student in the form of such topics as venereal disease, sex education, alcoholism, smoking, etc.

The schedule of meetings lists the following physicians as speakers: John M. Lesesne, M.D.; Paul Rizzo, M.D.; George R. Granger, M.D.; Edwin F. Dittmer, M.D.; William A. Lange, M.D.; Eugene J. Cetnar, M.D.; Scoville M. Hopkins, M.D.; L. W. Jodar, M.D.; R. C. Thumann, M.D.; D. E. Van Hoek, M.D.; Gomer P. Evans, M.D.; M. R. Stoyka, M.D.; and W. G. Levick, M.D.

The AMA handbook "Horizons Unlimited" is being passed out to those individuals who want some particular information. It is also being distributed to the high school counselors along with many other brochures of the various careers which we obtain. We shall be needing more of these handbooks when the fall program starts again in September. It is our hope that we shall have no difficulty in obtaining them from MSMS. Our desire is to obtain at least 100 of these handbooks for the September 1967 program.

There is a great need for similar programs in other areas of Detroit and I presume outstate also. However, we have been unsuccessful to date in getting other physicians or organizations interested in providing this service. A notice in the Michigan State *Medical Journal* several months ago indicated the need for this type of program and stated that the county medical society could provide assistance in establishing them. We have contacted members of the society in the past and thus far have been unsuccessful in getting the proper individuals interested in developing similar programs elsewhere in the county.

It is my opinion that part of the problem lies in the lack of understanding of the need and the inability of many individuals to realize what must be done to establish these programs. I feel that MSMS can be helpful in being more definitive in drawing up plans for similar programs elsewhere.

There is no question in my mind that the need for these programs does exist. The society could also be helpful in determining and obtaining the various pieces of literature of the many careers in the medical and para-medical fields that could be used by these organizations.

Tandearil®
oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.

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Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic joints move again

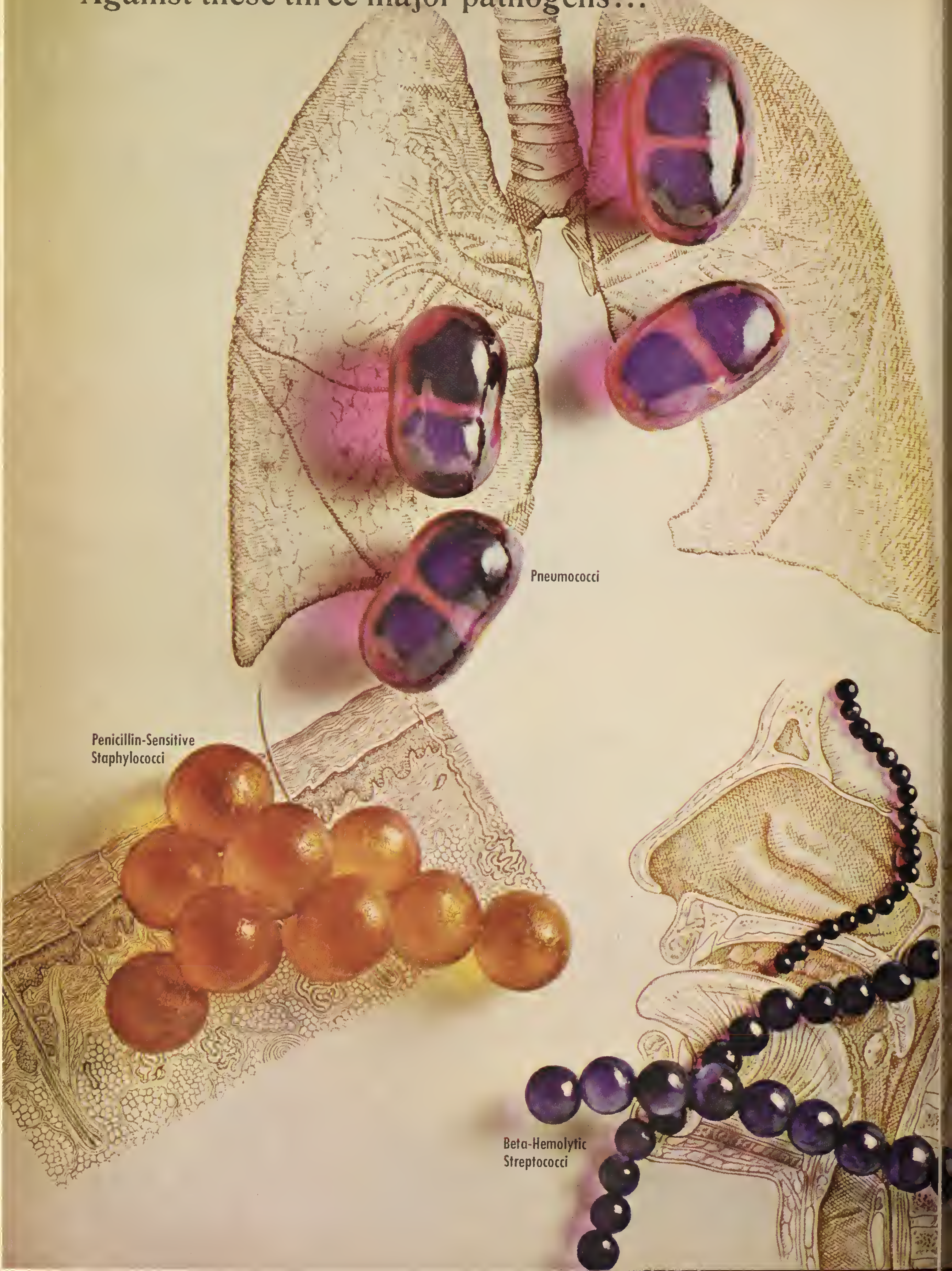
3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964.	76.9% of 407 patients
Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966.	84.6% of 39 patients

Please see adjoining page for brief prescribing summary.

TA-4919 PC

Against these three major pathogens…


Pneumococci
Penicillin-Sensitive Staphylococci
Beta-Hemolytic Streptococci

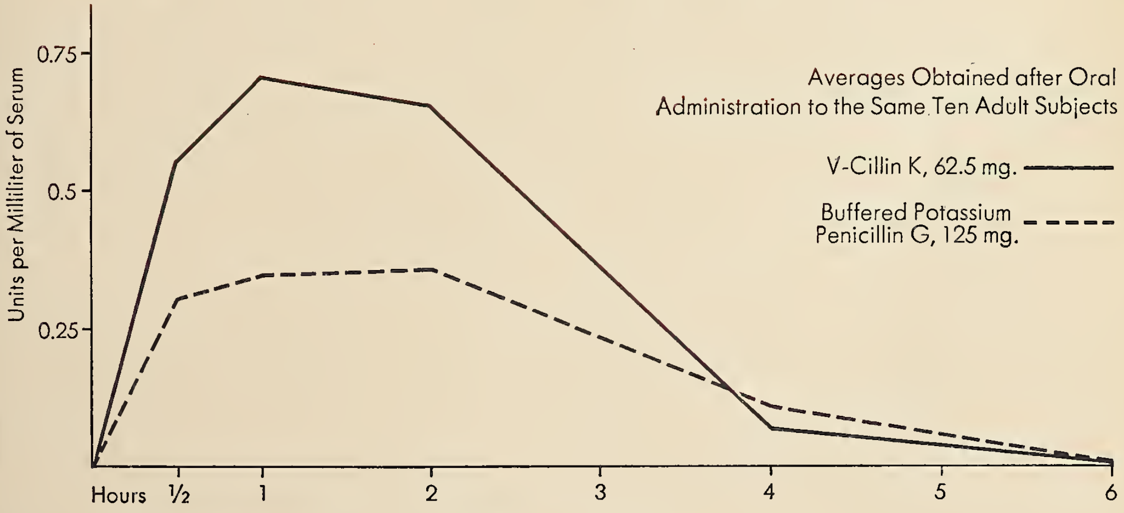
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Range	Streptococcus, Group A MIC (mcg./ml.) Median	Streptococcus, Group A MIC (mcg./ml.) Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Diplococcus Pneumoniae MIC (mcg./ml.) Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700636

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses

100
PRODUCT No. 1832
V-CILLIN K®
POTASSIUM PHENOXYMETHYL PENICILLIN TABLETS, U.S.P.
500 mg. (800,000 Units)
DATED
Lilly

Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with h parenteral dosage schedules, frequent evaluation of the renal hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory stu (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth pencillin-insensitive organisms. In such cases, its administration sho be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much common with administration of oral penicillin than with intramusc forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sig cant index of sensitization. The following hypersensitivity reacti associated with the use of penicillin have been reported: skin ras ranging from maculopapular eruptions to exfoliative dermatitis; caria; and reactions resembling serum sickness, including chills, fe edema, arthralgia, and prostration. Severe and often fatal anaphyl has occurred (see Warnings). Hemolytic anemia, leukopenia, thr bocytopenia, and nephropathy are rarely observed side-effects are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cilli Pediatric, the usual dosage ranges from 125 mg. (200,000 units) th times a day to 500 mg. (800,000 units) every four hours. For infa the daily dosage may be 50 mg. per Kg. of body weight divided three doses.

Beta-hemolytic streptococcus infections without associated b teremia may be treated with 200,000 to 400,0000 units three time day. Therapy should be continued for a minimum of ten days to prev development of rheumatic fever and/or other serious complicati Dosage for routine streptococcus prophylaxis in patients with a his of rheumatic fever or congenital heart disease may be 200,000 u once or twice daily. When such patients undergo tonsillectomy, tc extraction, or other minor surgery, the prophylactic dose should 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible on the of surgery, parenteral therapy should be considered. Mild to mo ately severe pneumococcus pneumonia has been treated effecti with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be gi every six to eight hours in conjunction with indicated surgical pro dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours three doses may be employed; in females, 500 mg. every four ho for six doses are recommended. Refractory infections generally resp to a second treatment three to four days following completion of first. Treatment of gonorrhea with severe complications should individualized, with prolonged and intensive treatment. Patients wit suspected lesion of syphilis should have a dark-field examination fore receiving penicillin and monthly serologic tests for a minimum three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units) bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lill

7C

omparison of Two Federal Programs: PL 89-749, Comprehensive Health Planning, PL 89-239, Heart, Cancer, Stroke

Editor's Note: The following article concen-
tes its attention on two Federal programs of
al concern to physicians. These programs are
L. 89-749, the Comprehensive Health Planning
d Public Health Services Amedments of 1966
d P.L. 89-239, the Heart Disease, Cancer, and
oke Amedments of 1965.

The Council of MSMS has made certain rec-
mendations to the Governor's Office for the
oper implementation of P.L. 89-749. It is also to
noted that MSMS is represented on the Board
Directors of Michigan Association of Regional
dical Programs [MARMP]. These activities
e MSMS active and interesting participation in
se programs to assist these, as well as other
grams, to take the proper and appropriate di-
tion.)

Congress has become increasingly aware of the fact that improved health care for the American people demands more complete cooperation between the Federal government, the universities, State and local government, State and local medical societies, the voluntary health interests, and individuals and organizations interested in creative action for health. Evidence of this awareness can be found in the complementary relationships between the Heart Disease, Cancer and Stroke Amendments of 1965 (Public Law 89-239) and the Comprehensive Health Planning and Public Health Service Amendments of 1966 (Public Law 89-749).

P.L. 89-239 authorizes grants to assist in planning, establishing, and operating regional medical programs to provide the health community with the latest information on the care of patients with heart disease, cancer, stroke and related diseases.

P.L. 89-749 establishes grants for comprehensive areawide and state-wide health planning, training of planners, and evaluation and development efforts to improve the planning art. As envisioned by Congress, the comprehensive planning efforts outlined in P.L. 89-749 would complement and build on the specialized planning of the regional medical programs provided for in P.L. 89-239. The following outline, as viewed by the U.S. Department of HEW, illustrates the interrelationship of programs and resources established by these two important programs.

(Continued on Page 914)

(Editor's Note: The analysis and comparison of these two programs to the dependence and the interdependence of each has been prepared by the U.S. Department of Health, Education and Welfare. It is to be **emphasized** *that MSMS is not responsible for the analysis and does not accept or reject in part or in toto the analysis as printed herein.)*

Sustained circulatory, respirato and cerebral stimulation for t

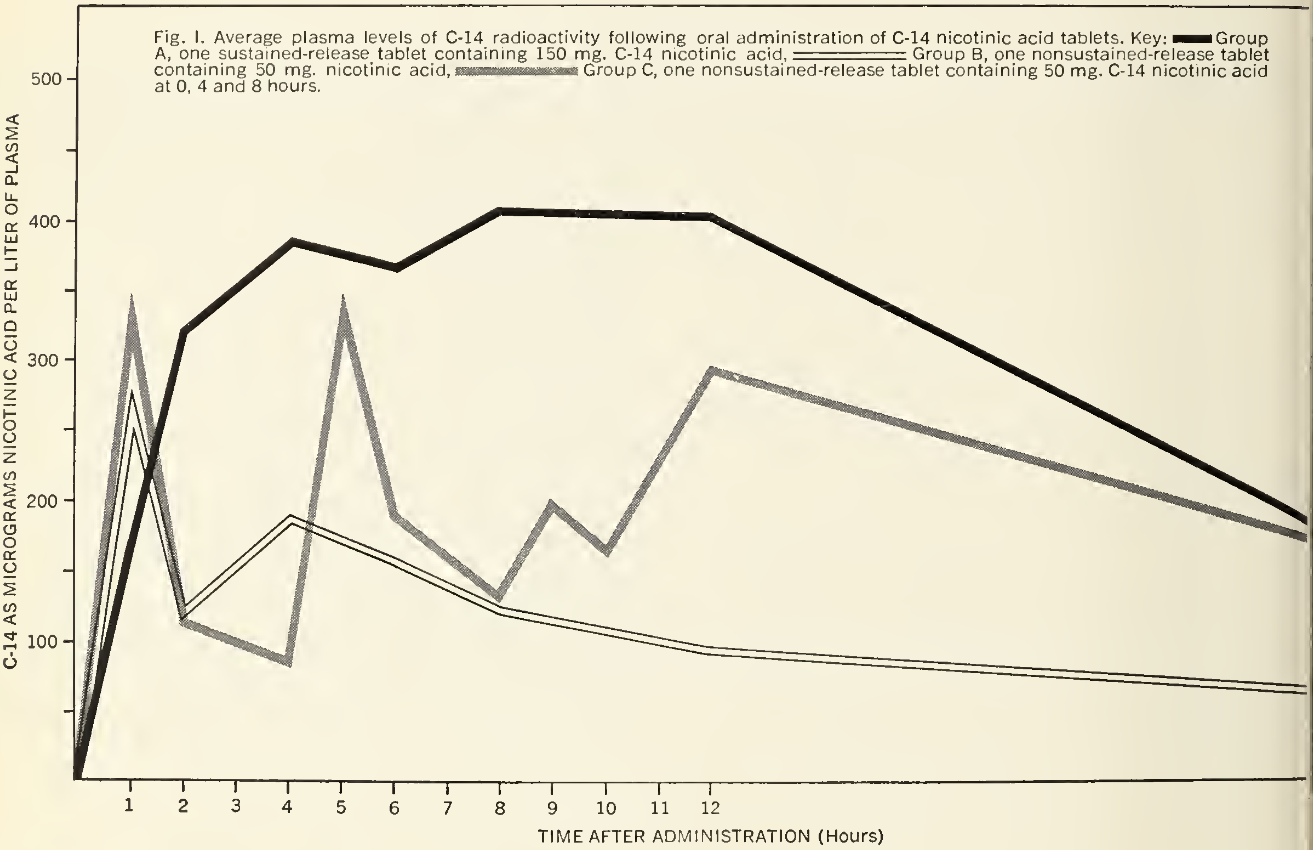


Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be c tinuous on a daily dose of only one Geroniazol TT t let every 12 hours.

The gradual release of nicotinic acid in Geronia TT will provide the well-known peripheral vasodila tion needed in patients with deficient circulation d with a minimum amount (if any) of "flushing." A cerebrovascular circulation is complemented by p tylenetetrazol, long-established as a cerebral and piratory stimulant.

Geroniazol TT improves the typical, unfortun signs of senile confusion. Patients become more al

ed and debilitated

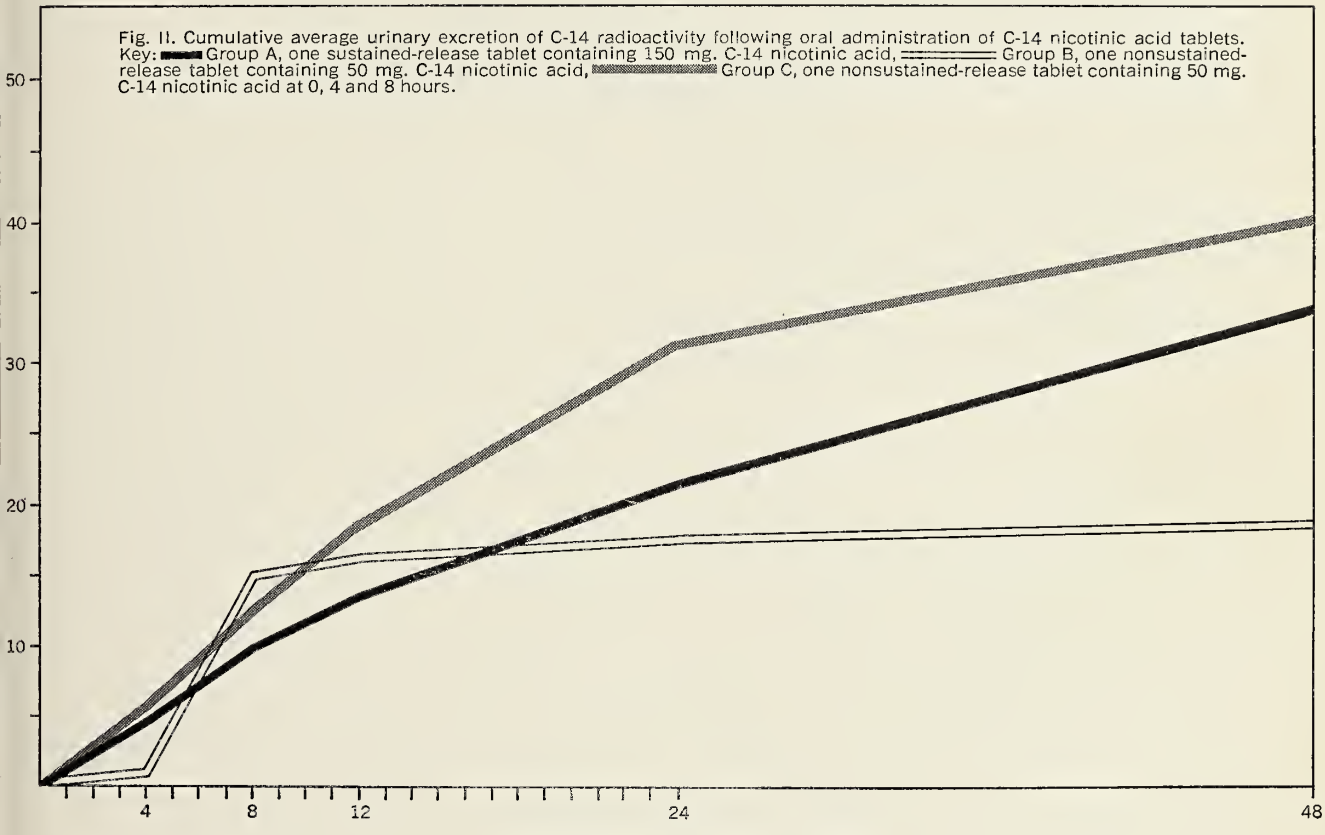


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ■ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

s confused and moody. Personal care, memory, iotional stability, social attention improve. Fatigue, athy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will rmit your patients to enjoy the benefits of time-olonged nicotinic acid/pentylenetetrazol therapy, an economical price. Dosage is only one tablet every hours.

ntraindications: There are no known contraindica-ns.

ecautions: Exercise caution when treating patients th a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

P.L. 89-749
THE COMPREHENSIVE HEALTH PLANNING PROGRAM

(PROGRAM SCOPE)

To establish a planning process to achieve Comprehensive Health Planning on a state-wide basis which identifies health problems within the state, sets health objectives directed toward improving the availability of health services, identifies existing resources and resource needs, relates the activities of other planning and health programs to the meeting of these health objectives, and provides assistance to state and local officials, to private voluntary health organizations and institutions, and to other programs supported by PHS grant funds in achieving the most effective allocation of resources in accomplishing these objectives.

(PROGRAM PARTICIPANTS)

State agency designated by the Governor does the planning. State advisory council advises on the planning process. Membership must include more than half consumer representation. Membership will also include voluntary groups, practitioners, public agencies, general planning agencies, and universities.

(PROGRAM PROCESS)

1. Establish state and areawide health goals.
2. Define total health needs of all people and communities within area served for meeting health goals.
3. Inventory and identify relationships among varied local, state, national, governmental and voluntary programs; regional medical programs, mental health, health facilities, manpower, Medicare — so that these programs can be assisted in making more effective impact with their resources.
4. Provide information, analyses, and recommendations which can serve as the basis for the Governor, other health programs and communities to make more effective allocations of resources in meeting health goals.
5. Provide a focus for interrelating health planning with planning for education, welfare and community development.
6. Strengthen planning, evaluation, and service capacities af all participants in the health endeavor.
7. Provide support for the initiation and integration of development and pilot projects for better delivery of health services; develop plans for targeting flexible formula and project grants at problems and gaps identified by the planning process.

P.L. 89-239
THE REGIONAL MEDICAL PROGRAM

(PROGRAM SCOPE)

To identify regional needs and resources relating to heart disease, cancer, stroke, and related diseases and to develop a regional medical program which utilizes regional cooperation to apply and strengthen resources to make more widely available the latest advances in diagnosis and treatment of these diseases.

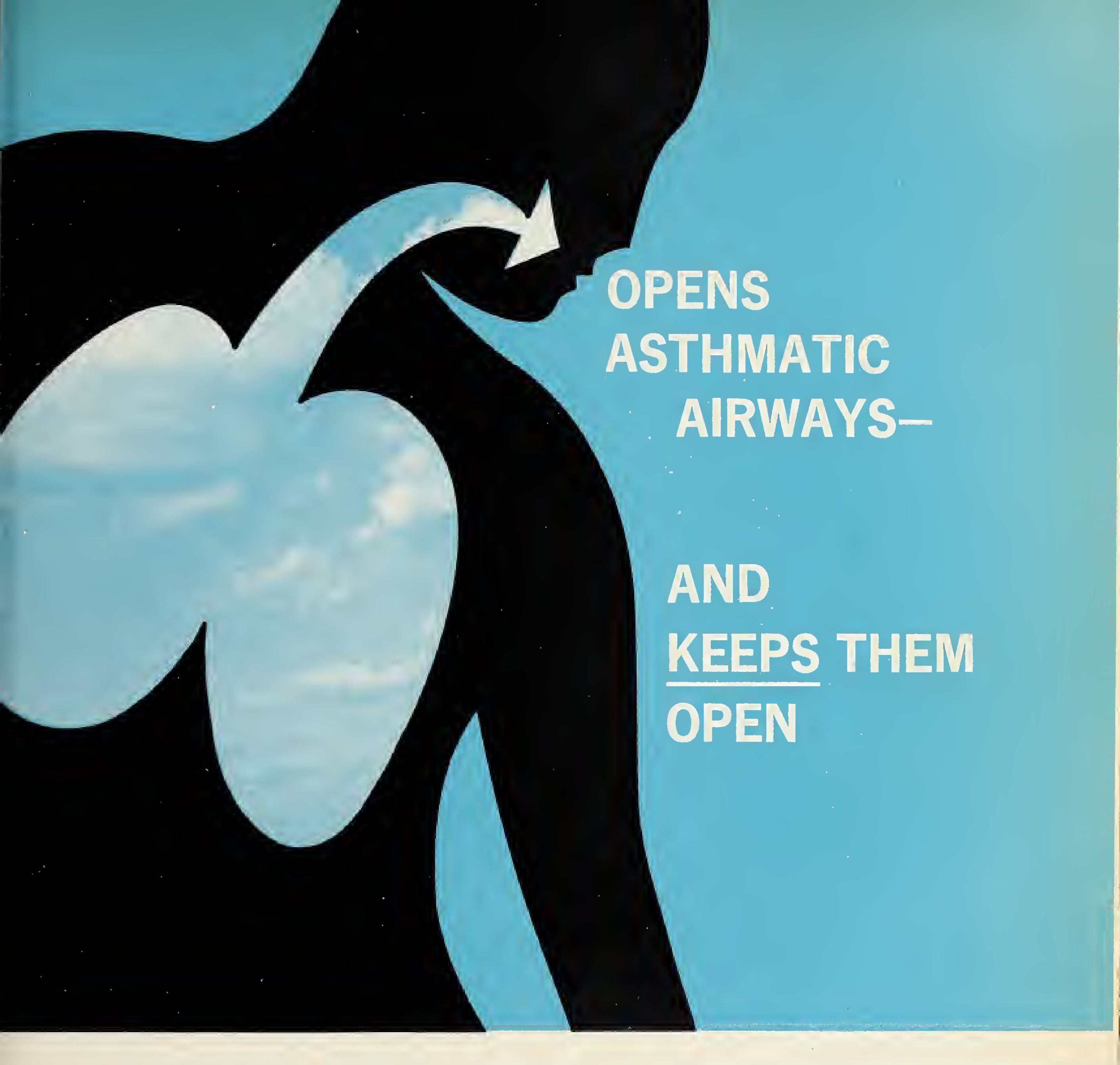
(PROGRAM PARTICIPANTS)

University medical centers, hospitals, practicing physicians, other health professions, voluntary and public health agencies, and members of the consumer public. A regional advisory group representing these interests and playing an active role in the development of the regional program must approve any application for operation activities of the regional program.

(PROGRAM SCOPE)

1. Establish cooperative arrangements among science, education, and service resources.
2. Assess needs and resources.
3. Develop pilot and demonstration projects, emphasizing flow of knowledge in uplifting the cooperative capabilities for diagnosis and care of patients.
4. Relate research, training, and service activities.
5. Develop effective continuing education programs in relation to other operational activities.
6. Develop mechanisms for evaluating effectiveness of efforts in the provision of improved services to patients with heart disease, cancer, stroke and related diseases.

(Continued on Page 916)



NUMA® DURA-TABS®

for *prolonged* aid to ventilation

Each Numa Dura-Tab provides:

theophylline	225 mg.
ephedrine HCl	50 mg.
butabarbital	25 mg.

(Warning: butabarbital may be habit-forming.)

Numa Dura-Tabs provide *prolonged* three-way action to ease breathing. Theophylline, a potent bronchodilator with minimal effect on the CNS, opens air passages and reduces bronchial spasm. Ephedrine HCl improves breathing capacity through its decongestant action. Butabarbital, a mild sedative, allays fear and apprehension.

Dosage: One Numa Dura-Tab every 8 to 12 hours helps keep the asthmatic patient symptom-free all day/all night.

Precautions: Use with caution in cardiovascular or hyperthyroid disease, severe hypertension, circulatory collapse, prostatic hypertrophy, or glaucoma.

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(QUINIDINE GLUCONATE 5 gr.)

P.L. 89-749 AND P.L. 89-239

(Continued from Page 914)

The relationships outlined above provide the key to a federally-planned integration of the many specialized health programs supported by the Public Health Service and the states.

In addition to Regional Medical Programs (P.L. 89-239), ongoing activities such as community mental health centers, areawide health facility planning, and Hill-Burton programs are stimulating the creation of new relationships between health resources and functions. Each of these programs require participation not only by a broad range of health professionals but also by the consumers of health services. Each of these programs is dependent upon the interaction of the full range of relevant health interests, including those in the public sector and the private voluntary sector in achieving the particular program goals.

Comprehensive health planning (P.L. 89-749) is designed to provide assistance in the development of more effective relationships among such health programs and to provide a better basis for relating these programs to the accomplishment of overall health objectives at the state and local level. As an example, the comprehensive health planning activities will use data obtained by the Regional Medical Programs (P.L. 89-239) not only to facilitate state and areawide planning, but also to assist other programs in meeting their objectives without duplication of effort.

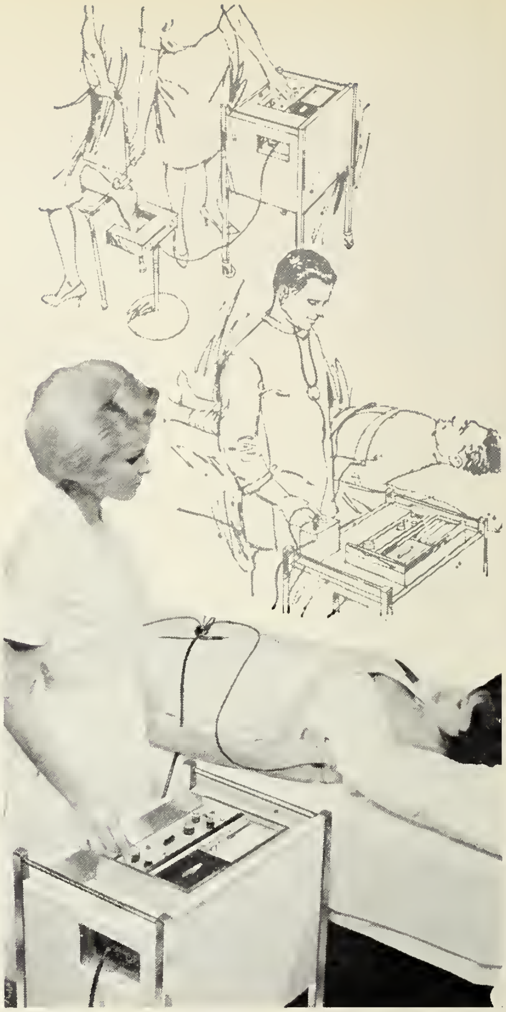
The planning resources created at the state and local level under Public Law 89-749 will be of real value in meeting the objectives of Public Law 89-239, and other programs of the Public Health Service and the States. The plans, programs and organizational framework being created under the Regional Medical Programs also should help the areawide and State-wide councils created under P.L. 89-749.

Other programs supported by Public Health Service funds such as mental health, migrant health, and air pollution can have the same kind of productive interrelationship with the comprehensive health planning programs.

To insure a more meaningful cooperation for health planning, there will need to be an increase in the supply of competent health professionals and planners.

Public Law 89-749 does authorize grants to public or nonprofit organizations for "training, studies, and demonstrations," in order to advance the state of the health planning art.

For the first years, emphasis will be placed on increasing health planning manpower. (Until now, Public Health Service effort has been limited to ad hoc short courses or inservice training.)



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Know the convenience of taking electrocardiograms (ECG), phonocardiograms (PCG) and photomotograms (PMG) right in your own office with this moderately priced equipment group. Self supporting, the **EK 4* Electrocardiograph,** with auxiliary **PC-100 Heart Sound Preamp** and **FM-1 Photomotograph** will give you needed diagnostically accurate facilities for a better, more comprehensive patient service. Call your Burdick dealer, or write us.

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help tip the scales for your "should-but-can't" dieters...

- ☐ controls the appetite
- ☐ provides gentle 'lift' to strengthen patients' determination to stick to dietary instructions
- ☐ simple, easy-to-remember dosage
- ☐ special timed-release mechanism ensures smooth, uniform, 10-12 hour therapeutic effect
- ☐ proved clinically safe in over 80 million doses
- ☐ the preferred HCl salt for more available amphetamine

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TIMED CAPSULES

℞

AMODEX® Timed capsules

n AMODEX TIMED CAPSULE contains:

extro-amphetamine HC1	15 mg.
mobarbital (barbituric acid derivative)	60 mg.

WARNING: may be habit forming

SAGE: One capsule on arising or at breakfast. Drugs are released lually over 6 to 8 hours, providing therapeutic effect for 10 to 12 rs.

ICATIONS: AMODEX Timed Capsules elevate the mood, relieve ner- s tension, restore emotional stability and emotional capacity for sical and mental effort. AMODEX Timed Capsules are extremely use- in the treatment of anxiety states and may be used to control etite in the management of the obese patient — without nervous tation.

SIDE EFFECTS AND PRECAUTIONS: Frequent or continued use may cause nervousness, sleeplessness, or restlessness. Individuals suffering from high blood pressure, heart disease, diabetes, thyroid disease, lung ailments, or kidney disorders should not take this product. It should not be taken over a long period of time.

CONTRAINDICATIONS: Hyperexcitability, agitated pre-psychotic states. Sensitivity to Amphetamines or Barbiturates.

CAUTION: Federal Law prohibits dispensing without prescription.

SUPPLIED: In bottles of 30, 100, and 1000 capsules.

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pharmaceuticals since 1866
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Offers Opinion on Giving Pill to Minors

This is in response to your inquiry with respect to the potential liability a doctor faces in dispensing contraceptive pills to girls under the age of twenty-one. There is no ironclad rule laid down by Michigan statutes or court decisions so, necessarily, there is much uncertainty in this area.

In general, medical treatment of minors requires the consent of the parent or guardian except in the case of an emergency. Medical treatment without such consent is an assault and battery upon the patient for which a doctor may be liable in damages. The legal age of adulthood in Michigan is considered to be twenty-one years but circumstances such as marriage or emancipation will affect whether or not a certain individual has reached adulthood and has the mental capacity to give an informed consent to medical treatment prior to reaching twenty-one years of age.

Parental consent for the prescribing or dispensing of contraceptives for a minor child under seventeen years of age is, I believe, imperative because a child of such "tender years" is not likely to have sufficient mental capacity or independence from her parents to give a valid consent. Further, when the parents discover that their child has been given birth control pills, they may involve a physician in a criminal charge of contributing to the delinquency of a minor.

Although it is probable that many emancipated eighteen-, nineteen-, and twenty-year-old girls, that is, girls who are not subject to parental custody or control and who are earning their own living, have the capacity to give an informed consent, prudent practice suggests the advisability of obtaining parental consent before dispensing any contraceptives to any unmarried girl under twenty-one years of age. The consent of the girl is also recommended in these cases.

The case of the married minor girl is another matter. Although the Michigan statutes release legally married minors from parental control, sixteen- to eighteen-year-old girls may not marry in Michigan without parental consent. Therefore, before dispensing contraceptive pills to married girls under eighteen years of age, it is recommended that parental consent, in addition to the husband's consent, be obtained. Married minor girls over the age of eighteen should have the capacity to give an informed consent, and generally, the patient's and the husband's conse should suffice to protect the physician from l ability. However, each case must be individuall considered; if there is any doubt about the p tient's or her husband's capacity to understan the situation, the safe procedure would be to ol tain parental consent before dispensing or pr scribing any contraceptives.

I am enclosing a form of consent which migh serve as a guide to you and your lawyer for you own special needs.

Sincerely yours,
A. Stewart Kerr,
MSMS Legal Counse

MCCC Offers Help With Cancer Programs

The Michigan Cancer Coordinating Committe is offering assistance now to county medical s cieties to hold one-day cancer demonstration pro grams throughout Michigan.

The MCCC urges physicians to help mak available additional postgraduate education in cancer, and it offers to arrange for the speake and pay his expenses and an honorarium.

Interested county medical societies can advis the MCCC as to possible meeting dates, places times, subjects, and other details.

Additional information may be obtained by con tacting Oscar D. Stryker, M.D., Mt. Clemens, Pro gram Coordinator for the Professional Educatio Committee, Michigan Cancer Coordinating Com mittee, 120 West Saginaw, East Lansing 48823.

Arthur Clements, center, who has met with many MSMS committees over the past 20 years, received a Certificate of Commendation from the Michigan Medical Service recently as he retired as assistant secretary. Signing the citation were John M. Wellman, M.D., left, Lansing, board chairman, and John C. McCabe, MMS president.

Speaking of Malpractice Insurance....

Have you checked the advantages of insuring with Shelby Mutual Insurance Company? This plan is sponsored by Michigan Association of the Professions and is available to members of the Michigan State Medical Society.

Here is why it might be beneficial for you to investigate

* Very Broad Coverage

* Competitive Premiums as Shown Below

Limits	Class 1	Class 2	Class 3	Class 4	Premises Minimum Premium
100/300,000	$97.00	$122.00	$234.00	$349.00	$27.00

(Premises Coverage Required with Professional Liability)

Class 1 — PHYSICIANS — No surgery.

Class 2 — PHYSICIANS — Minor surgery or assisting in major surgery on own patients.

Class 3 — SURGEONS — General practitioners who perform major surgery or assist in major surgery on other than own patients.

Class 4 — SURGEONS — Specialists.

Write for complete information as to coverage and premiums.

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mail bag

I want to express my sincere thanks and that of the Michigan Diabetes Association for printing the fine article on our camp for diabetic children.

I am sure your article will give us much needed publicity. We are capable of handling many more children than we have in the past.

It is due to the training in the care of their own diabetes that we find our alumni from this camp well able to live active and normal lives.

We appreciate no end your thoughtfulness in printing this article.

Sincerely yours,
William M. LeFevre, M.D., Chairman
Committee on Diabetes
Michigan State Medical Society

Many thanks for including a portion of one of my releases on federal spending in your issue of *Michigan Medicine*.

Your readers may be interested to learn that our efforts have been somewhat successful and are continuing to gain support. Recent action on the Post Office-Treasury Department appropriation saw $112 million knocked off in committee and then an additional $2.4 million cut on the floor. While this falls short of the minimum 5% across-the-board cut we will be seeking on most appropriations bills, it is significant and hopefully indicates a trend toward economy.

I enjoy reading your publication and look forward to hearing from your readers on the national issues which you cover so intelligently.

Thanks again,

Sincerely,
Marvin L. Esch
U.S. Representative
2nd District, Michigan

Congratulations on the excellent Workshop On Medical News Reporting that your group held last Friday at the University of Michigan.

We felt it was a complete success and that the information given will be of great help to individual doctors, medical societies, news media representatives, and PR people. The comments that we heard, from others who attended, backed up our estimate.

Thanks for inviting us. We're already looking forward to the next Workshop which we believe you said will be held at Wayne State University in 1968.

Sincerely,
C. R. Shelton
Executive Offices
Park, Davis & Company
Detroit, Michigan

I want to express my sincere thanks and that of the Michigan Diabetes Association for printing the fine article on our camp for diabetic children.

I am sure your article will give us much needed publicity. We are capable of handling many more children than we have in the past.

It is due to the training in the care of their own diabetes that we find our alumni from this camp well able to live active and normal lives.

We appreciate no end your thoughtfulness in printing this article.

Sincerely yours,
William M. LeFevre, M.D., Chairman
Committee on Diabetes
Michigan State Medical Society

Noted and Quoted . . .

"In the words of Postmaster General O'Brien the Post Office "is in a race with catastrophe." A preview of doom was, in fact, experienced last fall at Chicago where at one point some 10 million pieces of mail were logjammed. This particular situation, though dramatic, was indicative, unfortunately, of the general state of our postal system. Under these conditions, we are probably receiving much better mail service than we should expect.

"As you know, the Postmaster General has now suggested that the Post Office be removed from Cabinet status and set up as a non-profit government corporation operated by a board of directors appointed by the President and confirmed by the Congress. A special Commission on Postal Organization was appointed by the President on April 8th to explore the idea.

"This would be radical surgery, but something on this order may be the only cure, and I believe it deserves this prompt and careful study.

"One thing I have long felt as necessary is legislation which I have joined in sponsoring to remove the appointment of postmasters from all political considerations and base them solely on merit."

—Congressman Charles E. Chamberlain,
Sixth District; Lansing

"The man who does not read has no advantage over the one who cannot read."

"When I couldn't even smell corned beef and cabbage,
I decided it was time for you, Doc."

Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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new members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Richard C. Agnew, M.D., 564 Fisher Building, Detroit, 48202.

Rosemarie Blosen, M.D., 2160 Gorno Court, Trenton, 48183.

Virgilio Bonet, M.D., 2765 Flushing Road, Flint, 48504.

Norman A. Carter, M.D., 739 Mott Foundation Building, Flint, 48502.

David E. Congdon, M.D., 2630 Sloan Street, Flint, 48504.

Avelina P. Estanislao, M.D., 5790 M-15, Clarkston, 48016.

Ali Guner, M.D., 629 W. Riverside Drive, Ioni 48846.

James H. Harper, M.D., Detroit Memorial Ho pital, Detroit, 48226.

Jack W. Hill, M.D., 6850 Division Avenue, S Grand Rapids, 49508.

Lanny L. Johnson, M.D., 903 E. Grand Rive Avenue, East Lansing, 48823.

Louis S. Leland, M.D., 1737 David Whitney Buil ing, Detroit, 48226.

Ulrich Moeser, M.D., 1447 N. Harrison, Sagina 48602.

Edward L. Moorhead, II, M.D., 100 Michiga Street, N.E., Grand Rapids, 49503.

Richard Plogenhoef, M.D., Otsego, 49078.

Donald R. Quigley, M.D., 701 N. Logan Stree Lansing, 48915.

James R. Reese, M.D., Ford Motor Compan Dearborn, 48127.

Alexander N. Rota, M.D., Sinai Hospital, Detroi 48235.

Gary Ruoff, M.D., 1416 W. Milham Road, Kal mazoo, 49002.

Nelson S. Schafer, M.D., 1602 N. Ballenger Hig way, Flint, 48504.

Gordon P. Scratch, M.D., 1005 Mutual Buildin Detroit, 48226.

(Continued on Page 926)

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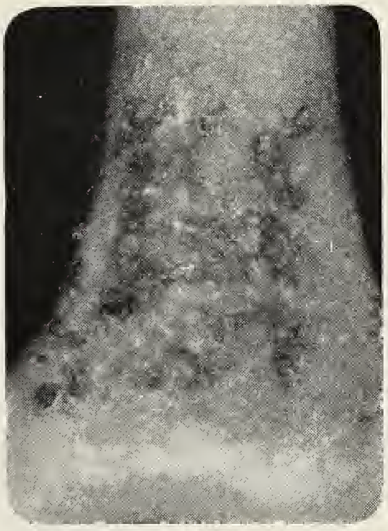
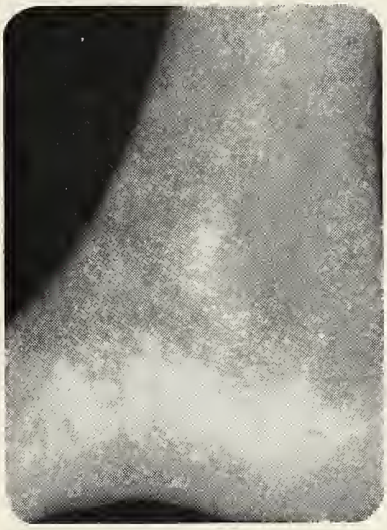


Before treatment



After treatment—
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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Triamcinolone Acetonide
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NEW MEMBERS/Continued

Mary S. Stahly, M.D., Sinai Hospital, Detroit, 48235.

Peter K. Stratton, M.D., 3815 Pelham Road, Dearborn, 48124.

Liong G. Tan, M.D., 888 Chalmers, Detroit, 48215.

Bonnie R. Wolfram, M.D., 620 New Center Building, Detroit, 48202.

John H. Bethea, M.D., 49000 West Seven Mile Road, Northville, 48167.

Willard S. Holt, Jr., M.D., Mt. Carmel Hospital, Detroit, 48235.

Leonard Price, M.D., Ferris State College, Big Rapids, 49307.

Herbert H. Hagermoser, M.D., 412 Eastland Center Building, Detroit, 48236.

Leland B. Phelps, M.D., 111 S. Chestnut, Reed City, 49677.

George Pusczak, M.D., 213 Elm Street, Big Rapids, 49307.

Gordon F. Van Otteren, M.D., 245 State Street, S.E., Grand Rapids, 49502.

Oscar C. Mitchell, M.D., 858 West Boston Boulevard, Detroit, 48202.

Alison W. Scringeour, 201 Lafayette Avenue, S.E., Grand Rapids, 49503.

Douglas Treadgold, M.D., 1323 Military Street, Port Huron, 48060.

MICHIGAN AUTHORS

Charles E. Lucas, M.D., and Clifford D. Berson, M.D., both of Detroit, "Chronic Bleedin Duodenal Ulcer in Childhood Managed by Hemigastrectomy and Vagotomy," *Surgery*, March 1967

FACILITIES PLANNING REGIONAL GROUPS SET

The Michigan Health Facilities Planning Council has announced completion of organization o five outstate regional bodies to coordinate healt care planning throughout Michigan.

The work of developing the program was begu in October 1965 with the support of the Hospita Research and Educational Reserve of Michigan Inc., parent body of the State Council, the Michigan Hospital Association, Michigan State Medica Society, Michigan Association of Osteopathic Hospitals, Michigan Association Osteopathic Physician and Surgeons, Blue Cross, Blue Shield, and th Ford Motor Company.

The Michigan Health Facilities Planning Council is offering staff assistance to the newly created councils in developing programs and compiling statistical data to provide the necessary background information for future planning deliberations.

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ACademy 7-1211

Check what you hear with a heart sound tracing

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Auscultation and phonocardiography should complement each other in your clinical diagnoses — the former by helping you assess the musical and non-musical character of sounds and murmurs, frequency composition and variations . . . the latter by pinpointing the precise beginning and ending of sounds and murmurs within the cardiac cycle. Chart tracings of sounds, for example, may help identify points of occurrence and duration characteristic of certain innocent and pathologic murmurs . . . delineate the delay and first sound accentuation in mitral stenosis . . . or isolate the typically high-pitched murmur between the first and second sounds in aortic stenosis, which might otherwise appear pansystolic because of the low or inaudible intensity of the second sound. To further aid the precise determination of timing of sounds and murmurs, *combined ECG-PCG recording* will clearly reveal the location of the sound within the cardiac cycle. The Hewlett-Packard 1506A Heart Sound Amplifier enables you to do just that — in conjunction with a 500 Viso cardiograph or other 2-speed instrument with adequate frequency response. By electronically measuring and sampling the heart sound signal at a frequency within the Viso's recording capability, the 1506A permits diagnostic-quality PCG's to be recorded by the 500 Viso.

The compact, self-powered Amplifier clips to the front of your 500 Viso, allowing diagnostic PCG's, ECG's, or the PCG superimposed on the ECG, to be recorded. Switch-selected filter positions of 50, 100, 250 and 500 Hz (cps) permit excellent recording clarity and separation of the frequency range of interest. In addition, the Amplifier is supplied with an Audiophone to give you a highly efficient electronic stethoscope, with separate controls for listening and recording. (As a teaching tool, the Amplifier and ECG let the user see the sounds recorded, *hear* them, and correlate the two with the ECG.)

Contact your local HP medical instrumentation specialist for complete technical details of the 1506A Heart Sound Amplifier — $450 with microphone, audiophone and cable, FOB Waltham, Mass., Cont. U.S. Hewlett-Packard Company, Sanborn Division, Waltham, Mass. 02154. In Europe: HPSA, 54 Route des Acacias, Geneva. 17754

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Three Michigan newspapermen learned more about medical manpower needs from U-M Dean William N. Hubbard, Jr., M.D., third from left, during the luncheon at the recent MSMS Conference on Medical News Reporting at Ann Arbor. Left to right are Roger Williams, Assistant Executive Director, Michigan Press Association; Boyce Rensberger, Detroit Free Press science editor; Dean Hubbard, and William Schiffel, Grand Rapids science writer.

The importance of accurate reporting of medical news was stressed during the luncheon conversation at the recent MSMS Conference on Medical News Reporting at the University of Michigan by four participants. Left to right are Carl Brahce, U-M medical school information officer who was instrumental in helping to arrange the U-M conference; Al Hansen, WFDF Flint; Lowell Treaster, MSU director of information, and a U.M. senior journalism student.

Honor Ingham Coaches

Six members of the Ingham County Medical Society received Certificates of Commendation in recognition of their services as high school team physicians in the County. The certificates were presented at the Society's monthly meeting, June 20.

Those honored included Franklin Troost, M.D., Holt High School team physician for 34 years; Matt S. Hurth, M.D., Lansing, Gabriels High School for more than 30 years; S. P. Fortino, M.D., Lansing, 20 years, Lansing Eastern High School; Robert June, M.D., Lansing, 10 years, Sexton High School; Royal E. Hames, M.D., Lansing, 8 years, East Lansing High, and Donald R. McCorvie, M.D., 8 years, Williamston High.

MSU NURSING SCHOOL RECEIVES A.V. GRANT

The School of Nursing at Michigan State University has received a grant from the United States Public Health Service of $264,681 for three years to make faculty time more effective by developing programed texts, films, slides, sound tapes, and other audiovisual aids which can be used in the classrooms and independent study carrels.

The project will enable students to do more independent study, allowing the faculty more time for individual student contracts.

PATHOLOGISTS CONFER

The Chief of the Ophthalmic Branch of the Armed Forces Institute of Pathology spoke at the recent meeting of the Michigan Society of Pathologists.

Lorenz E. Zimmerman, M.D., spoke on diagnosis, treatment, and prognosis at the meeting at Sparrow Hospital in Lansing. The one-day seminar was attended by pathologists as well as opthalmologists from throughout the state.

PMA Asks FDA Repudiate Survey

"Public charges by the FDA against pharmaceutical manufacturers followed months later by private apologies scarcely seems appropriate or sufficient."

So declares C. Joseph Stetler, President of the Pharmaceutical Manufacturers Association about the much-discussed FDA survey of drugs.

"Four PMA members have received letters of apology from FDA admitting it was wrong," Mr. Stetler reports.

"Forty PMA firms analyzed their allegedly violative products and found only one percent deviated from acceptable potency limitations," he added.

FDA, in its survey, said it found 7.6 percent of them deviated.

Mr. Stetler recently demanded the FDA to "repudiate the survey outright." The PMA on five occasions has requested the FDA for details of the survey. Mr. Stetler says "gross inaccuracies" were found in subsequent reanalyses by the companies and independent labs.

With regard to improper use of the findings, Mr. Stetler said "FDA's failure to notify the companies involved indicates the survey has been utilized as a vehicle for an unwarranted attack on the prescription drug industry, rather than as a basis for working with producers to correct possible deficiencies. As such, it has offended rather than served the public interest."

The study has been widely quoted in the press. On four occasions senators who support prescribing and dispensing legislation have quoted the study in the *Congressional Record.*

in memoriam

C. Bandy, M.D.

estus Cecil Bandy, M.D., who formerly prac- d in the Upper Peninsula died May 14 at the of 78 in Sarasota, Florida.

octor Bandy received his M.D. degree from University of Louisville in 1912, and was for ny years affiliated with War Memorial Hospital ault Ste. Marie.

urther details were unavailable at the time of lication.

R. Boothby, M.D.

aul R. Boothby, M.D., Lawrence physician e 1944, died April 17. He was 56.

orn in Gobles, Michigan, Doctor Boothby was luated from the Oklahoma University of Medi- and began his practice in Lawrence 23 years He had been a resident of Paw Paw for the three years.

urther information was not available at the of publication.

. Ciprian, M.D.

oseph E. Ciprian, M.D., longtime Detroit phy- n, died April 22. Doctor Ciprian was 72.

native Detroiter, Doctor Ciprian was grad- ed from Wayne State University in 1917 with .D. degree. He interned at St. Mary's Hospital, Detroit Memorial, and began his general ctice in Detroit.

ffiliated with Grace Hospital, Doctor Ciprian's cial interest was geriatrics.

e was a Life Member of the Michigan State lical Society and the American Medical As- ation.

ward H. Cummings, M.D.

Page 872)

. Gahagan, M.D.

homas J. Gahagan, M.D., staff member of the oracic Surgery Department at Henry Ford Hos- l, died May 5 at the age of 41.

octor Gahagan received his pre-medical train- at Colgate University and his M.D. degree n Wayne State University.

e was a member of the American Board of gery and had served in the United States Air ce.

octor Gahagan was affiliated with Henry Ford pital for 15 years.

F. E. Hansen, M.D.

Frederik E. Hansen, M.D., Birmingham, who retired in 1959 from the staff of Crittenton General Hospital, died May 18. He was 78.

Born in Copenhagen, Denmark, Doctor Hansen received his medical degree from Wayne State University, having completed pre-medical training at Ohio State University. He did postgraduate work in Copenhagen, Edinburgh, and at Cook County Hospital in Chicago.

During World War I Doctor Hansen served in the United States Army.

Doctor Hansen was an emeritus member of the International College of Surgeons, a Life Member of the Interstate Post-Graduate Medical Assembly, the American Medical Association, the Michigan State Medical Society, and of University Lodge, Number 482, F & AM. His medical fraternity was Nu Sigma Nu.

L. E. Himler, M.D.

Leonard E. Himler, M.D., Ann Arbor, past Chief of Staff at Mercywood Hospital, died April 30. He was 63.

Doctor Himler held A.B. and M.D. degrees from the University of Michigan.

Doctor Himler served as president of the Michigan Society of Psychiatry and Neurology, consultant to the Michigan Department of Social Welfare, chairman of the AMA Committee on Mental Health in Industry, and consultant to the University of Michigan Institute of Industrial Health. He was a member of the Group for the Advancement of Psychiatry of the American Psychiatric Association, Industrial Medical Association, Central Neuropsychiatric Society, American Academy of Neurology, International League Against Epilepsy, American Public Health Association, and the MSMS Committee on Mental Health.

Civic memberships included Rotary International. His medical fraternity was Phi Chi.

Doctor Himler was an associate professor of community mental health at the University of Michigan Medical School.

I. C. Sweet, M.D.

Irwin C. Sweet, M.D., Sterling, Director of District 7 for the Michigan Public Health Service since 1948, died May 3. He was 61.

Doctor Sweet received his pre-medical training at Park College, Parkville, Missouri, and at the University of Michigan. He was graduated from the University of Nebraska College of Medicine in 1932 with his M.D. degree. In addition to his medical degree Doctor Sweet also held a Master of Public Health from the University of Michigan.

In 1963 Doctor Sweet became the first district health officer to receive the Michigan Health Officers Association Distinguished Service Award.

In 1961 he was elected President of the Michigan Health Officers Association.

Doctor Sweet has served as secretary-treasurer of the staff at Community Hospital in Standish, secretary of the MSMS Section on Public Health and Preventive Medicine, and from 1933 to 1936 in the United States Army.

His medical fraternity was Alpha Kappa Kappa.

Government-Private Balance Discussed

A delicate balance must be maintained between government and the private health sector in the development of community health plans, John C. McCabe, president of Michigan Blue Shield, said at the annual Upper Michigan Health Congress at Northern Michigan University.

Any imbalance would cause such programs to lose their vigor and result in a negative effect on the quality of care, Mr. McCabe told an audience including representatives of the Michigan Health Council and 15 para-medical health organizatio

"We must be alert, always careful that t balance will be preserved and that governm will not extend its involvement in the health c field, or find it necessary to do so," he warn

"Community health service programs, wh formulated, must be of the highest quality. should include health promotion, health edu tion, family planning, prevention of disease, di nostic treatment, counseling and referral serv Their availability, accessibility, and acceptabi must be adapted to all members of the com nity young and old," he said.

Mrs. Brenneman Dies

Mrs. June Brenneman, wife of MSMS Execut Director Hugh Brenneman, died May 28 from juries sustained in an automobile accident. A f mer teacher, Mrs. Brenneman was active in co munity and church affairs, taking much interest local music, art, and drama groups.

BOOKS RECEIVED

Ethics in Medical Progress. (Ciba Foundati Symposium). Edited by G. E. W. Wolstenhol and Maeve O'Connor. 257 pp. Illustrated. $11.

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Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

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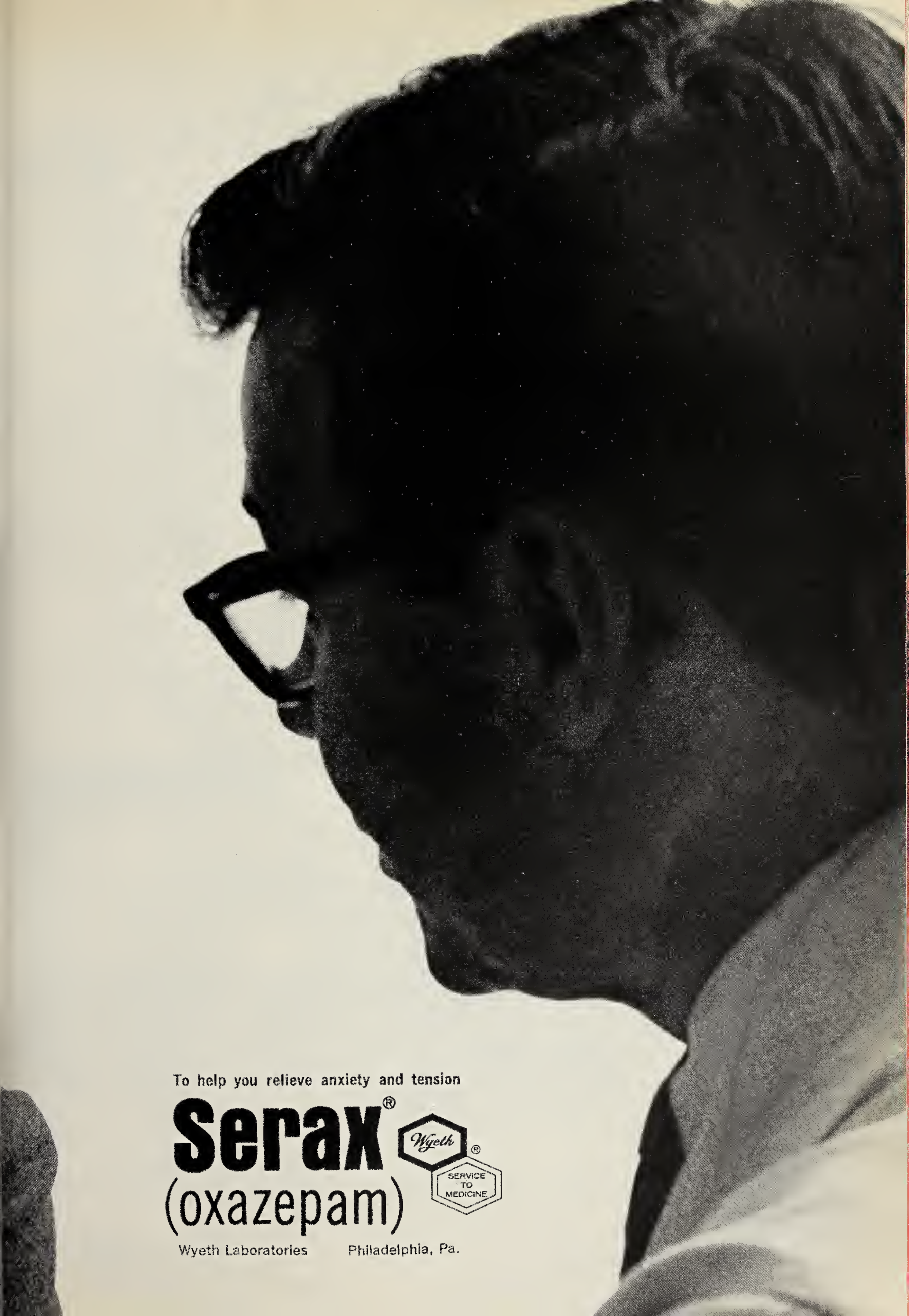

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MICHIGAN MEDICINE
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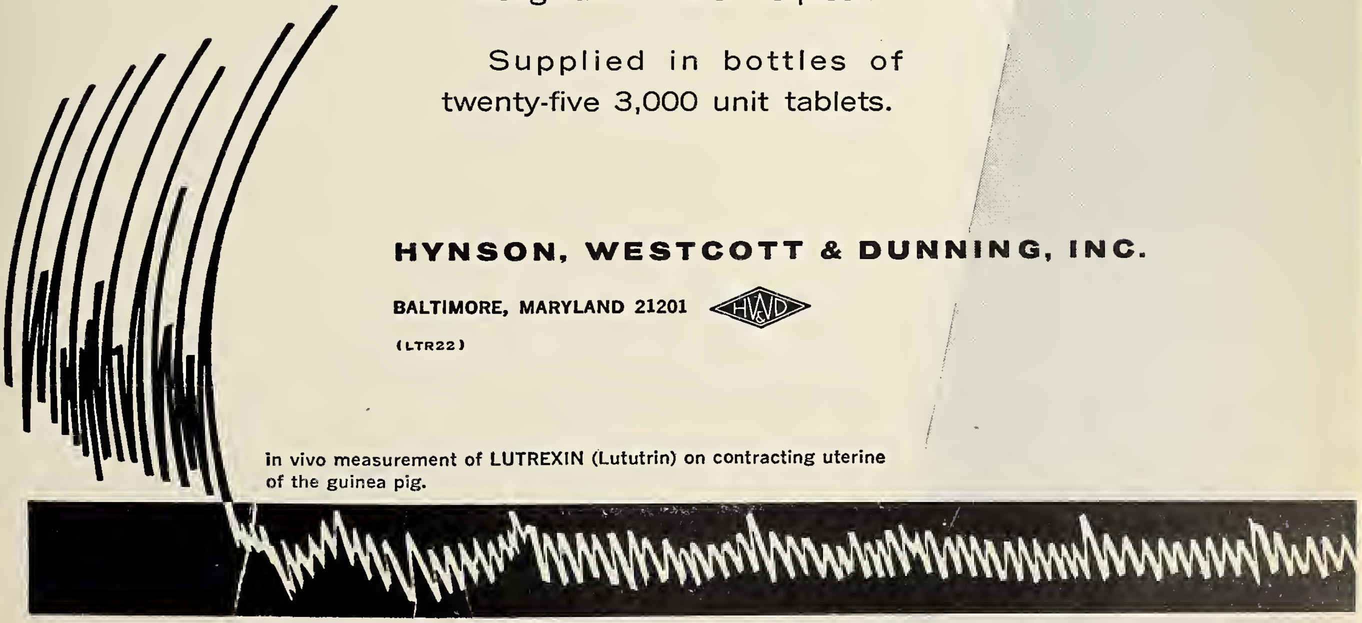

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Volume 66, Number 15

The artist catches some of the spirit of debate and discussion at the annual meetings of the MSMS House of Delegates, and the theme of the cover invites interested MSMS members to observe the Delegates in action, in Grand Rapids, September 24-25-26. Appreciation is voiced to the AMA Communications Division, which loaned the art work.

*Apologies are extended to George E. Bacon, M.D., Instructor in Pediatrics, Department of Pediatrics and Communicable Diseases, University of Michigan, for a typographical error in his paper which appeared in the June issue. The error was in the byline, and the article is reprinted in this issue in an effort to express our regrets to Doctor Bacon.

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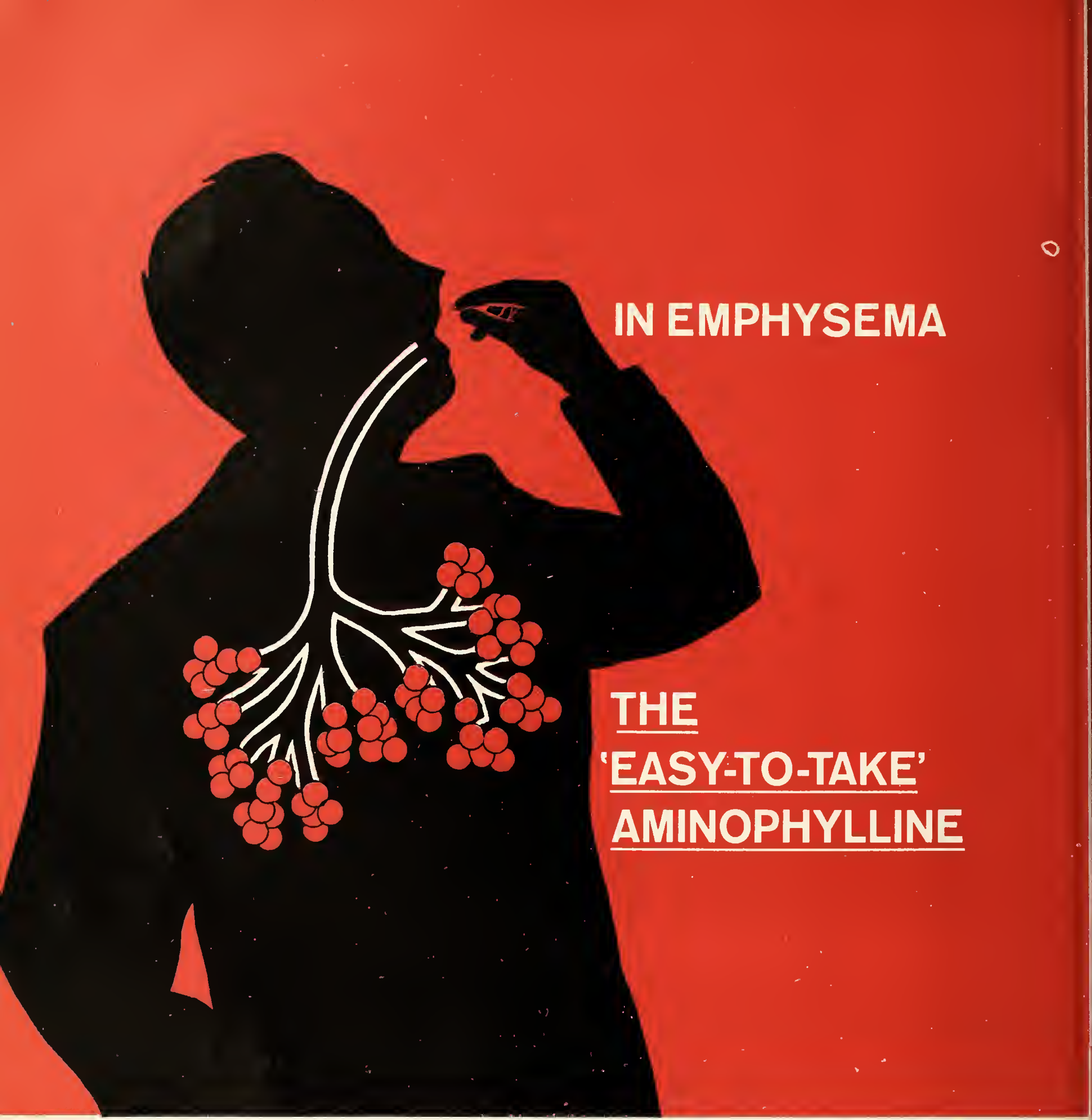

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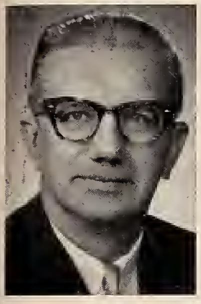


president's message

COMMENTS ON MEDICAID:

To say that the implementation of Title XIX (Medicaid) of Public Law 89-97 in Michigan, as well as in many other states, is a "mess" is understating the problem 1000 percent.

The limitations on coverage owing to a lack of funds, the problems inherent in establishing a new statewide vendor payment system, and the various interpretations of the federal legislation and its implementation on the state level have caused great confusion both among physicians and the program's beneficiaries. After discussing this problem with many physicians throughout the state, the following points need to be made:

Leaders in each county medical society should make it abundantly clear to all persons in their respective communities that medical care is available to all who need it. No one can deny that each physician has the right to accept or reject individual patients for care and treatment. On the other hand, organized medicine, as the leader in health field, has the duty and responsibility to make sure that medical care is available to all citizens.

The direct billing to beneficiaries of this program only adds to the confusion and deters patients from seeking medical care. Already there is proof that this confusion on the part of the beneficiaries is reaching high governmental officials and may further damage the doctor's public image. Physicians are strongly opposed to the vendor payment system established by Title XIX of P.L. 89-97, but it is the law.

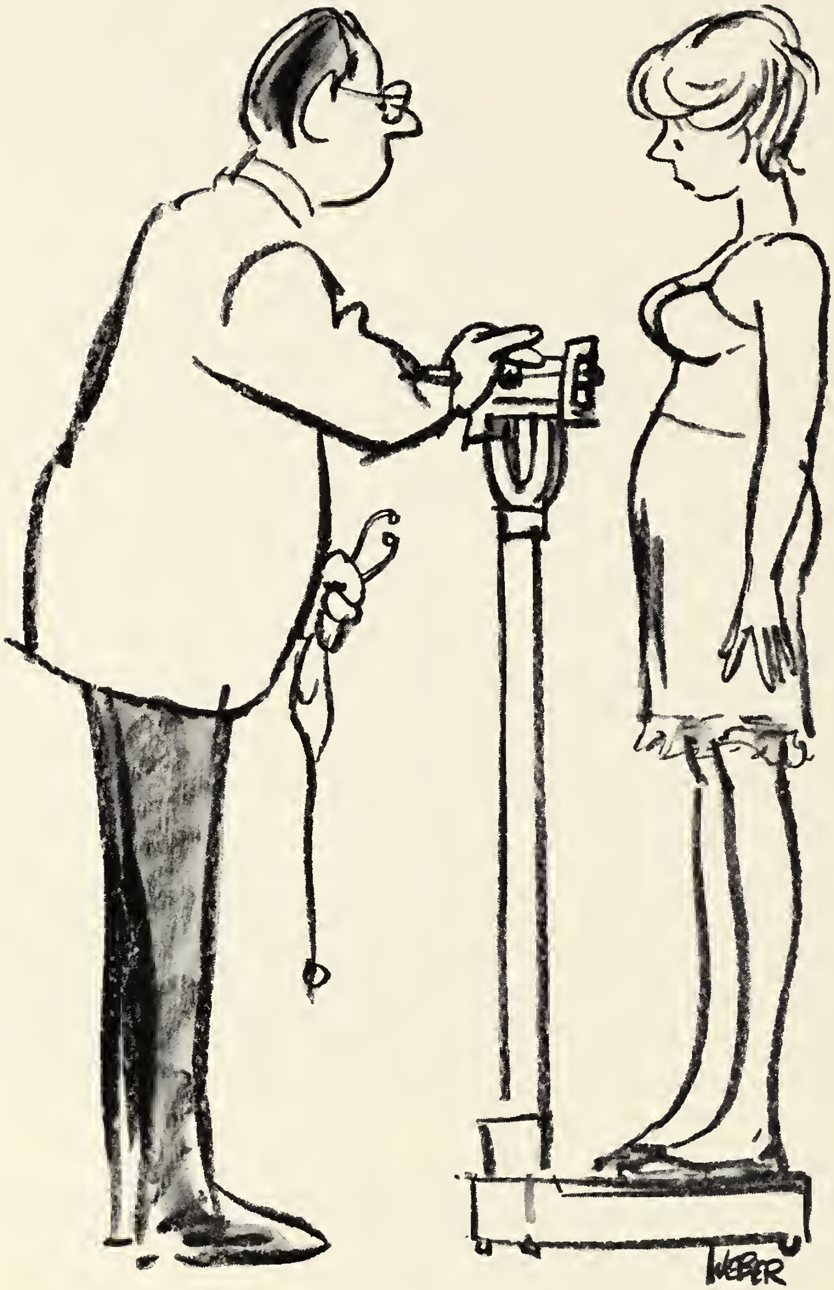
At the present moment there are two alternatives to this illegal direct billing: 1) giving the needed treatment without thought of remuneration, a situation physicians have practiced for centuries, or 2) billing by the established assignment technique. Until such time as the law can be changed, it is the opinion of most medical leaders that one of these two alternatives should be used.

All physicians, both individually and through organizations, must seek to change those parts of Title XIX which are not desirable or necessary. Legislation permitting direct billing and making other important changes has already been introduced into the Congress and is now being considered by the House Ways and Means Committee.

The Michigan State Medical Society, in conjunction with other state organizations, has and is exerting its influence to bring about the necessary changes. It is equally important that each physician recognize this problem and communicate with the members of the House Ways and Means Committee and his own congressman and senators, pointing out his ideas both as a citizen and physician. This is one of our most effective ways to correct the legislation which is inimicable to our American way of life.

However, until the necessary changes are made, I believe it is our duty to assure all citizens of medical care and to remain within the law.

C. Allen Payne MD



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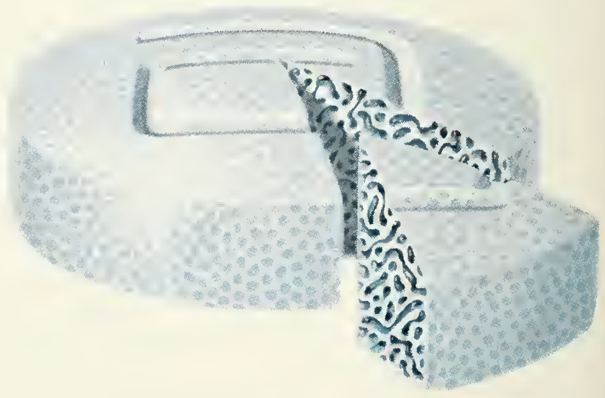

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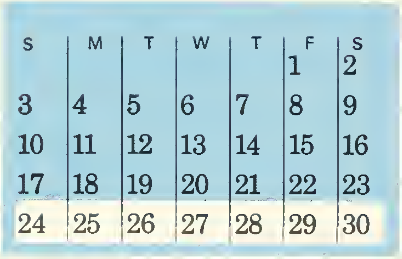

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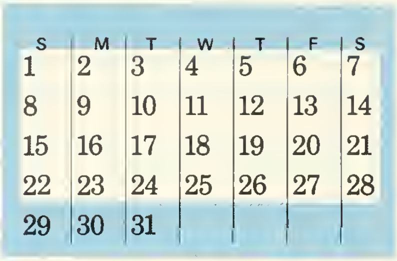

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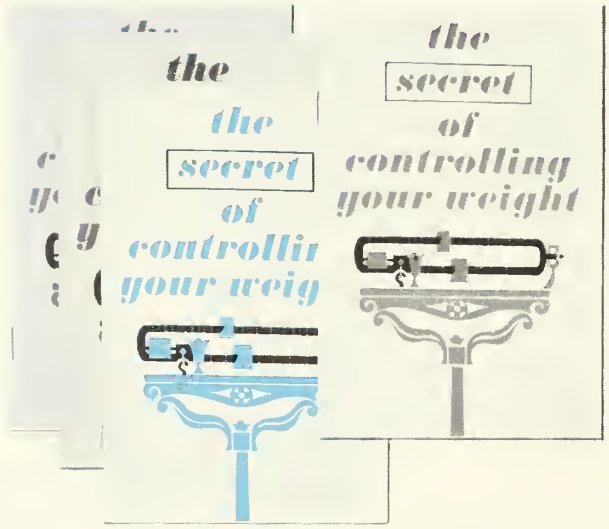

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Hoping to involve descendants of the original subscribers to the old Detroit Medical College in Wayne State University's centennial celebration, the Centennial Commission still needs information about families of the following persons and companies: James F. Joy, Philo Parsons, Christian H. Buhl, A. C. McGraw, Merrill I. Mills, Allan Shelden, Henry P. Baldwin, Caleb Van Husan, George S. Frost, Hiram Walker, William A. Butler, John Owen, Buckminster Wight.

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Anyone having information on descendants of these persons or companies should forward it to Ronald Russell, TE 3-1400, Ext. 7348, Wayne State University.

AMA HONORS WXYZ

Detroit television station WXYZ has been awarded a first-place in the AMA's annual awards for outstanding examples of journalism that "contribute to a better understanding of medicine and health in the United States."

WXYZ-TV received the award for editorial writing, one of the five categories granted prizes. The station's series on measles immunization won a $1,000 cash prize and a plaque.

Youth Commission Joins VD Efforts

The Michigan Youth Commission, in its annual report to Governor Romney, reviewed joint efforts with the Michigan State Medical Society in the fields of venereal disease education, family life education and smoking-health. Members of the MYC include Robert M. Heavenrich, M.D., Saginaw; Irving Posner, M.D., Detroit; Eleanor Skufis, M.D., Adrian, and Herbert A. Auer, of the MSMS staff.

WIVES AID AMA-ERF

The Woman's Auxiliary to the Oakland County Medical Society recently contributed $500 to AMA-ERF. The Auxiliary designated $100 each for each of the three Michigan medical schools and $200 towards the AMA-ERF Bio-Medical Research.

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SCIENTIFIC ARTICLE

Cutaneous Complications Of Smallpox Vaccination

Y RALPH J. COSKEY, M.D.
ENRY G. BRYAN, M.D.
OTH OF DETROIT

Most of the population of the United States ave been repeatedly vaccinated against smallpox. Neff *et al.*[1] estimated that there were 14,014,000 mallpox vaccinations given in 1963. They estimated that there were approximately 433 compliations following vaccination. Their figures repreented the more serious complications, since they were taken primarily from recipients who were iven vaccinia immune globulin. Seven persons died in 1963 from vaccinations, two with eczema vaccinatum and five with post vaccinal encephaliis. Kempe[2] analyzed data from questionnaires eceived from 19,616 physicians and estimated that there were 3000 complications from smallpox vacination in 1963.

This paper discusses the cutaneous complications een after smallpox vaccination and describes paients with these complications who were seen in our dermatology practice.

VACCINIA NECROSUM

Vaccinia Necrosum (Vaccinia gangrenosa) may occur in vaccinated patients with Hodgkins diease, leukemia, blood dyscrasias and other condiions in which corticosteroids, ionizing radiation, and/or antimetabolites are being given. It may also occur in patients with dysgammaglobulinemia, agammaglobulinemia, and, rarely, in otherwise normal people.

In this condition the vaccination site fails to heal and becomes progressively larger and necrotic. This may be associated with pneumonitis, myocarditis, osteomyelitis, and death.

Patients with this complication usually have no neutralizing antibodies to vaccinia virus.[2,3,4,5] An adolescent white female with Cushings disease is a good example of this condition (Figure 1).

GENERALIZED VACCINIA

Generalized vaccinia most commonly develops from auto-innoculation. It may also rarely occur as a result of general infection. In the latter the lesions develop from four to ten days after vac-

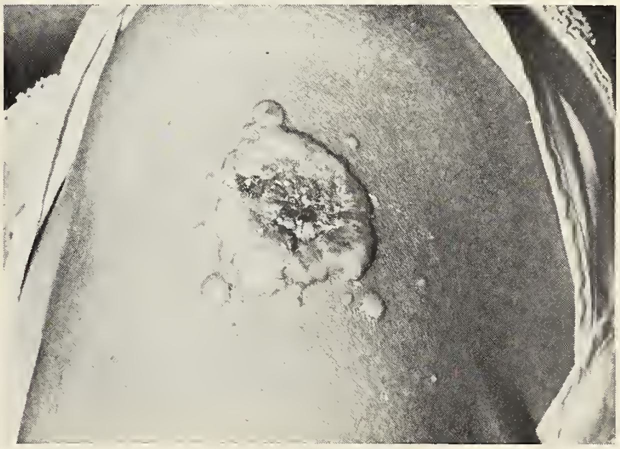


Figure 1. Progressive vaccinia on upper arm of adolescent white female with Cushings disease.

Doctors Coskey and Bryan are clinical instructors, Department of Dermatology, Wayne State University School of Medicine, and Junior Associates, Detroit General Hospital.

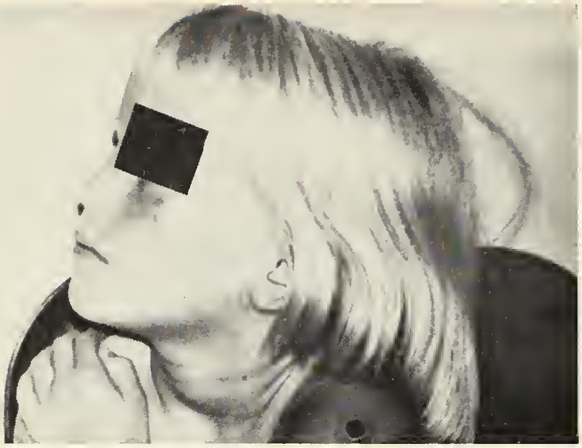


Figure 2. Generalized vaccinia: vesicular lesions on the face and active vaccination site on the left upper arm (Case 1).

cination. They evolve from papules to vesicles, then pustules, and appear in crops, producing lesions in various stages of development. They may involve any part of the cutaneous surface and may be few or numerous. They usually undergo a complete resolution in 21 days.[6]

> Case 1: 6-year-old white female was seen on October 1, 1964, complaining of generalized pruritus of 24 hours duration, associated with nausea and headache. She had received her initial smallpox vaccination on September 16, 1964. A history of atopy was negative except for a cousin who "possibly" had eczema. Examination revealed a crusted vaccination site on the left upper arm. There were scattered red, descrete and confluent papules and vesicles on the face, neck, back, arms, and legs (Figures 2 and 3). The mucous membranes were clear. Weight was 44 pounds. On October 2, 1964, the patient was admitted to the hospital and was given vaccinia immune globulin, 5 cc in each hip for a total of 10 cc. She was discharged on October 5, 1964. When seen on October 8, 1964, the generalized lesions showed dry scaling only. On October 30, 1964, the skin was clear except for redness at the vaccination site.

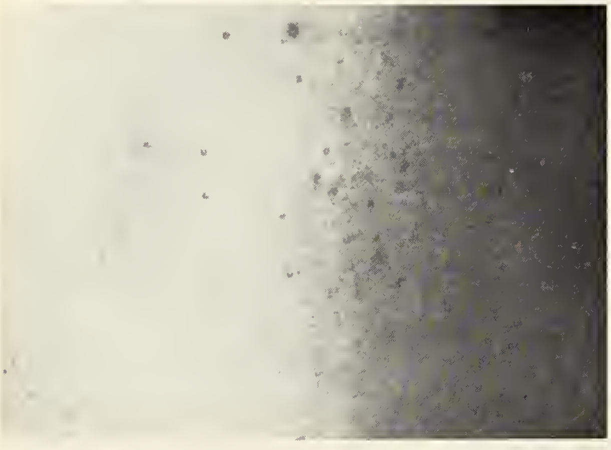


Figure 3. Generalized vaccinia: close-up view of widespread vesicular lesions on the back (Case 1).

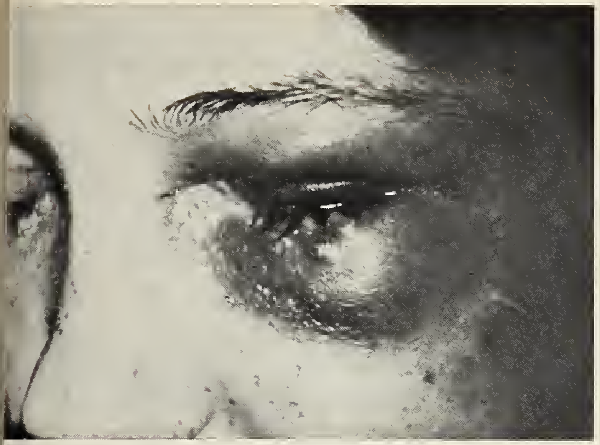
Generalized vaccinia may also develop in tl
human fetus after innoculation of the pregna
mother. Vaccinia is most common in infants
mothers vaccinated in the first trimester, but al
may occur in those vaccinated later in pregnanc
The virus takes one or two days to cross tl
placenta, and there is a ten to 12-day incubatic
period.[7, 8]

ECZEMA VACCINATUM

This is a condition characterized by the a
pearance of multiple vaccinial vesicles and pustul
on eczematous skin. Usually the incubation peric
is five to 19 days. The affected patients are usua
ly ill with a high temperature. The mortality ra
varies from 4 percent to 40 percent with differe
series.[9]

Eczema vaccinatum is usually a complicatic
of atopic dermatitis, but has been reported t
occur in patients with seborrheic dermatitis, co
tact dermatitis, secondary syphilis, impetigo, i
thyosis, acne, scarified areas, sites of electrodesi
cation, abrasions, and keratosis follicularis.[10]

> Case 2: A 22-year-old married white female was seen on October 2, 1963, complaining of swollen eyes of three-days duration. She had been taking TAO (triacetyloleandomycin) and Dimetane (brompheniramine maleate) for two days without improvement. She had had atopic dermatitis for many years. Her 10-months-old child had received an initial vaccination on September 21, 1963. The patient had been vaccinated during childhood without incident. Examination revealed swollen red eyelids bilaterally with numerous intact pustules (Figure 4). The left side was more pronounced. There was similar involvement of both external ears. There was dry, scaling, slightly red, patchy dermatitis in the antecubital fossae. The temperature was 99.4° F and the weight was 100½ lbs. On October 3, 1963, the patient was given vaccinia immune globulin 5 cc in each arm and each



gure 4. Eczema vaccinatum of the eyelid ase 2).

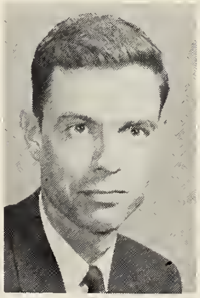
ABSTRACT — The cutaneous complications that occur after smallpox vaccination include vaccinia necrosum, generalized vaccinia, eczema vaccinatum, autoinnoculation, roseola vaccinosa, erythema multiforme, and bacterial infection.

The more severe complications can be prevented if vaccination is not given to patients with dermatitis, open skin lesions, tuberculosis, hypogammaglobulinemia, dysgammaglobulinemia, lymphoma, blood dyscrasias, and patients being treated with corticosteroids, antimetabolites, or radiation. Pregnant women should not be vaccinated. If a severe complication occurs, the patient should be treated with vaccinia immune globulin and possibly Methisazone.

hip for a total of 20 cc. On October 5, 1963, there was less swelling and no new pustules, the temperature was 99° F. The left lower lid showed entropion. On October 7, 1963, the patient was seen by an ophthalmologist who did not find any abnormality of the conjunctivae, corneas, or globes. Several of the pustules had cleared, and there was much less edema. Throughout the course the patient had been using Methaseptic compresses and Elase ointment (fibrinolysin and desoxyribonuclease) three times daily. On October 12, 1963, the patient was afebrile, showed macular erythema only, and was discharged from treatment.

A physician confronted with an individual aving an eczematous disease should not vaccinate im or members of his family. What should the hysician do with a person having atopic dermaitis that has cleared? Various authors give differnt opinions. Kempe[2] says that when the skin s relatively clear, vaccination may be done with attenuated vaccine or concomittant use of vaccinia immune globulin. Robertson[11] says a safe procedure would be to vaccinate children over 5 years of age who have been free of eczema for one year. If a child has eczema, he can attend school without the required vaccination, if an explanatory note is written by the attending physician. Copeman[12] goes so far to say that even if atopic eczema is quiescent, it is an absolute contraindication to vaccination, except if the patient is a contact of a known person with smallpox or is going to an area with endemic smallpox. If vaccination is essential, he recommends that vaccinia immune globulin be given prophylactically.

CO-AUTHORS



Henry G. Bryan, M.D.

Ralph J. Coskey, M.D.

AUTOINNOCULATION

Antoinnoculation may produce secondary vaccinal lesions. If it involves the ocular area it may cause a relatively painless ulcerative blepharoconjunctivitis. This may lead to loss of cilia, lid scarring, keratitis, and corneal opacities.[13] Autoinnoculation may also lead to generalized vaccinia with the appearence of a few or multiple lesions. The lesions develop at various times after vaccination, but rarely after three weeks.[6] Specific treatment is indicated when function of a vital organ is threatened.

Case 3: A 71-year-old white female was vaccinated on the right deltoid area on March 31, 1966. Seven days later she developed an erythematous nonfluctuant nodule on her left cheek. Her past history is significant in that she has had seborrheic dermatitis of the ears, preauricular area, and postauricular area for twenty years. The patient was initially seen on April 9, 1966, and at that time the nodule on the face was 2 cm in diameter and had a flaccid vesicle on its surface (Figure 5). The patient had at that time a temperature of 100°F and a primary take on the right arm. The patient was given 15 cc of vaccinia immune globulin on April 10, 1966. On April 12, 1966, she was afebrile, and the lesion on the left cheek had begun to decrease in size. Culture taken from the vaccinia lesion on the cheek was negative. The hemagglutination inhibitation titer against vaccinia virus was less than 1: 5 on serum taken on April 10, 1966, but was 1:160 on serum taken on April 25, 1966.

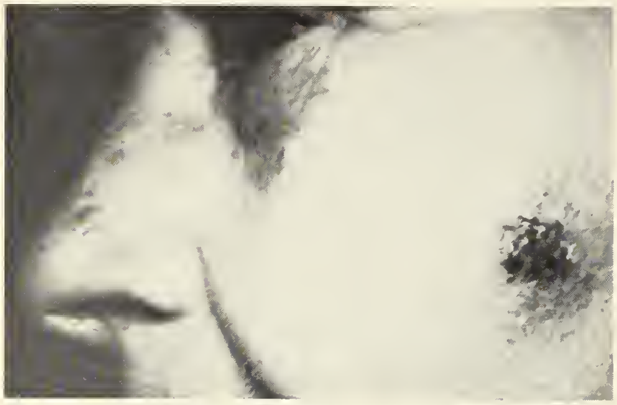


Figure 5. Autoinnoculation vaccinia on the left side of the face (Case 3).

NONVIRAL ERUPTIONS ASSOCIATED WITH VACCINIATION

Roseola vaccinosa is a minor complication that first appears about the site of the vaccination and then spreads to other parts of the body. The eruption is characterized by erythematous, irregular discrete macules, or even diffuse erythema. It usually begins about ten days after vaccination and lasts only a short time. Less commonly erythema multiforme or urticaria may be seen after vaccination.

Case 4: A 7-months-old infant was seen on June 25, 1966, because of an eruption involving the face, neck, back, chest, abdomen, and legs that was compatible with roseola vaccinosa. The eruption was characterized by multiple grouped and isolated red macules which measured 2 mm in diameter (Figure 6). These lesions blanched with diascopy. There was a primary "take" characterized by a 1 cm pustule with surrounding edema on the back. This patient was vaccinated on his back on June 18, 1966. On June 19, 1966, he developed an upper respiratory infection with otitis media which was treated with ampicillin (Polycillin). On June 24, 1966, the above asymptomatic eruption developed. By June 29, 1966, the eruption had faded, except for a few macular lesions on the legs.

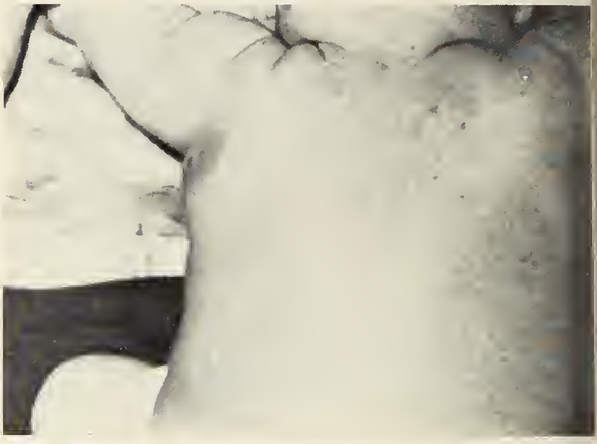


Figure 6. Roseola vaccinatum on the back. The vaccination site is seen on the left (Case 4).

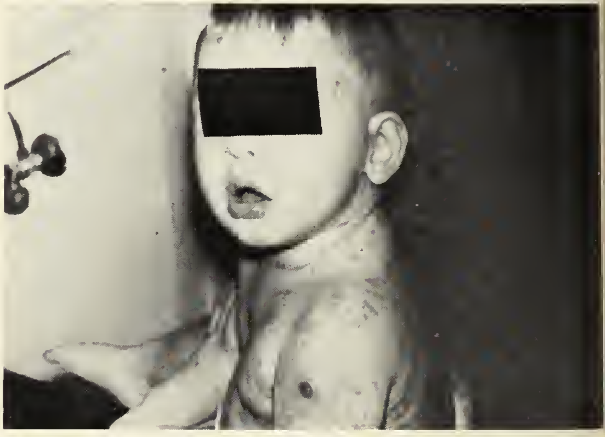


Figure 7. Generalized erythema multiforme following vaccination (Case 5).

Case 5: A 12-months-old white male, seen on March 19, 1965. The complaint was a generalized erythema multiforme-like eruption of three-days duration. The patient had received his initial vaccination on the left upper arm on March 9, 1965. Examination revealed circular, elevated, red, firm, discrete, and confluent plaques on the face, trunk, arms, and legs. A crusted vaccination site was present on the left upper arm (Figures 7 and 8).

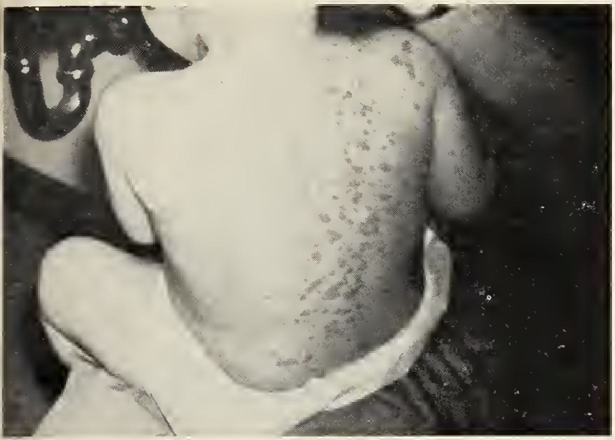


Figure 8. Erythema multiforme after vaccination (Case 5).

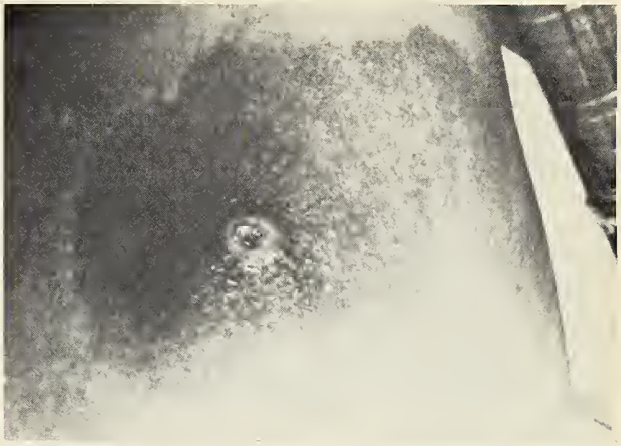


Figure 9. Secondarily infected vaccination site on the left upper thigh (Case 6).

BACTERIAL INFECTIONS SUPERIMPOSED ON THE VACCINATION

The vaccination site may become secondarily infected and thus impetigo, cellulitis, erysipelas, furunculosis, and lupus vulgaris may occur. It is possible for bacterial infection then to spread to other parts of the body.

Case 6: A 66-year-old white female was vaccinated on the upper left thigh on June 21, 1966. On June 25, 1966, the patient noticed increasing redness around the site of the vaccination. On June 28, 1966, she developed chills and fever with swelling in the left groin. She was started on Erythromycin 250 mg QID on June 29, 1966. She had had a vaccination during childhood without complication and with a residual scar on her arm. In 1956 a vaccination was given which did not take. Physical examination on July 1, 1966, revealed a 1 cm pustule on the left upper thigh with a tender surrounding zone of redness 10 cm in diameter (Figure 9). There were bilateral enlarged inguinal nodes which were more enlarged and tender on the left. The patient was advised to continue with the Erythromycin for eight more days, and the cellulitis resolved.

THERAPY

The severe complications of smallpox vaccination such as eczema vaccinatum, generalized vaccinia, vaccinia necrosum, and, in certain instances, autoinnoculation should be treated with human vaccinia immune globulin in a dosage of 0.6 to 1.2 cc/kg body weight. This preparation may be obtained from the American Red Cross Regional Blood Centers. Methisazone (Marboran), an experimental drug, may be used along with vaccinia immune globulin in the treatment of these complications.[14] This drug acts against the virus multiplying in cells.[15] Jaroszynska-Weinberger and Meszaros[15] found in a series of 55 children, vaccinated in spite of contraindications, who were given either vaccinia immune globulin or Methisazone, that those given Methisazone had smaller local vaccination reaction and these reactions healed faster than those patients treated with vaccinia immune globulin alone. Both drugs prevented vaccination complications. Methisazone is used in a dosage of 200 mg/kg orally initially followed by 50 mg/kg every six hours for three days. It should be stopped for three days and repeated again if necessary.

The nonviral eruptions require only symptomatic treatment, as the general rule[15] for spontaneous resolution. Corticosteroid therapy obviously should be avoided, but antihistamines and soothing topical lotions or baths are definitely helpful.

Secondary bacterial infections are treated with appropriate antibiotic therapy. Culture and sensitivity studies are ordered when necessary.

COMMENTS

In order to prevent complications from smallpox vaccination, one should not vaccinate persons with atopic dermatitis or other forms of dermatitis. Vaccination is also contraindicated in tuberculosis, patients with open skin lesions, hypogammaglobulinemia, dysgammaglobulinemia, lymphoma, and blood dyscrasias. Also, pregnant women and those being treated with corticosteroids, antimetabolites, and/or radiation should not be vaccinated. A child with atopic dermatitis may acquire vaccinia from contact with another recently vaccinated member of his family; thus, if a sibling or parent must be vaccinated, he or she or the individual with the skin disease should be removed from the household for two weeks.

If a person is to travel outside the United States and has a contraindication to vaccination, a written statement from his physician should be obtained stating why vaccination should not be given. This will be accepted by the Quarantine Service of the United States Health Service. If it is absolutely necessary to vaccinate a patient with a clinical contraindication to vaccination, then the patient should be given vaccinia immune globulin or Methisazone or both agents along with the vaccination.

SUMMARY

Physicians should be aware of the complications that may follow smallpox vaccination. We have attempted to describe cutaneous complications of vaccination that we have seen in our private practice. We also have discussed contraindications to vaccination and therapy for the complications that may result from vaccination.

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The Use of Long-Acting Phenformin In Diabetic Patients with Active Pulmonary Tuberculosis

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DETROIT AREA

ABSTRACT — Twenty-five patients with tuberculosis and diabetes mellitus were given phenformin to control their hyperglycemia. Twenty-two of the patients responded favorably, and the drug manifested no interference with antituberculosis therapy. Duration of the treatment was three to six months.

Hypoglycemic agents have been used with varying degrees of success in the management of diabetes mellitus during the last decade. Reports of studies with these new drugs are very limited in diabetic patients with pulmonary tuberculosis. We have been using oral hypoglycemic agents in diabetic patients with pulmonary tuberculosis, and our previous experience with tolbutamide, chlorpropamide, and short-acting phenformin had been very encouraging.[1]

There are certain advantages in the use of these agents in diabetic tuberculous patients:

1. Most severe diabetics are more effectively controlled by using phenformin in combination with insulin.
2. Initially, the far-advanced active tuberculous patients often require frequent small doses of insulin for control and may experience insulin reactions during the first couple weeks of treatment. Malnutrition, toxemia, dehydration, and other associated conditions probably account for the instability of the diabetes at this critical time. If the patient's underlying disease improves, within a few weeks the diabetes becomes more manageable. Our experience in these circumstances demonstrated that phenformin affords immediate advantage in reducing the frequency of insulin injections and avoidance of troublesome insulin reactions.
3. Avoidance of risk of hepatitis, discomfort, and the bother of repeated insulin administrations in diabetic patients.

Therefore, this new study was planned in our diabetic tuberculous population at Herman Kiefer Hospital using long-acting phenformin.*

MATERIAL AND METHODS

Twenty-five hospitalized patients with diabetes and active pulmonary tuberculosis were selected for the treatment with long-acting phenformin with or without insulin. All the subjects had been under our care for diabetes and tuberculosis for at least three months previously. Febrile and toxic cases were excluded. No other criteria were used in selection of the patients. All of them were carefully evaluated as to degree of control prior to this study. These patients had been treated previously in various ways, e.g., by diet, insulin sulfonylurea, and short — acting phenformin.

In 22 patients the following regimens had been previously tried: insulin in 21 instances, short-acting phenformin in seven, chlorpropamide in three, and tolbutamide in two. In addition, three patients with brittle diabetes and wide blood sugar fluctuations had received a combination of short-acting phenformin and insulin. Under these regimens the following result was reported: The degree of control was excellent in nine, good in seven, fair in two, and poor in three patients on insulin; it was excellent in four and good in three on short-acting phenformin; it was excellent in one, fair in one, and failure in one on chlor-

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The patients in this study are from the Herman Kiefer Hospital Diabetic Service, Detroit.

Doctor Gurol is in private practice in Farmington.

Doctor Chapman is tuberculosis controller, Herman Kiefer Hospital, Detroit.

Doctor DeJanney is associate director, Herman Kiefer Hospital, Detroit.

* Kindly supplied, in the form of DBI-TD, United States Vitamin and Pharmaceutical Corporation, New York, New York.

propamide; and it was excellent in one and good in one on tolbutamide; it was excellent in one and fair in two on insulin and short-acting phenformin.

After completion of the study all the patients were placed on short-acting phenformin without consideration of the previous treatment, unless they were failures. These were placed on insulin.

Duration of treatment with long-acting phenformin was from two to six months. The patients were observed for three to six months after they were placed back on short-acting phenformin or insulin. The total observation period was five to twelve months. The age range was 35 to 79. The duration of known diabetes prior to the beginning of the study was one to 37 years. The state of tuberculosis was judged as minimal in two, moderate in four and far advanced in 19 patients.

Patients with diabetic complications included five with retinopathy, five with nephropathy, and five with neuropathy. Significant associated diseases other than tuberculosis were two with cor pulmonale, three with hypertensive-arteriosclerotic heart disease, one with chronic pyelonephritis, one with hydronephrosis, one with cholelithiasis, one with bronchiectasis, one with liver cirrhosis, one with acute myocardial infarction, and one with pneumonia.

The patients who had been controlled on insulin or other hypoglycemic agents were started with a dose of 50-100 mg a day in the morning and adjusted according to their responses. The final dosage varied from 50 to 500 mg a day. All the patients had their insulin doses lowered by 25 to 75 percent during the first 7 to 15 days of treatment; thereafter, all the insulin was discontinued. The patients who had been controlled on sulfonylurea or short-acting phenformin were started with the same dose of long-acting phenformin. However, additional doses of regular insulin were given the first days of treatment while they were on fractional urine, if indicated.

The diet remained the same during and after treatment. The patients took 25 to 35 percent more calories than the calculated basal requirements. Fasting and postabsorptive blood sugar determinations were made by the Folin Wu method,[2] at varying intervals, depending on response. Fractional urine analysis for sugar and acetone four times daily was maintained throughout the study. Routine chest roentgenogram and sputum studies were continued as in the pretreatment period. All the patients remained in the hospital during the study.

RESULTS

Responsiveness to the drug was classified as excellent, good, fair, and failure. The patients classified as having an excellent response had postprandial blood sugar less than 180 mg percent or fasting blood sugar less than 120 mg percent al the times tested. They were aglycosuric. The patients classified as having good response had fasting blood sugar between 120 and 140 mg percent and postabsorptive blood sugar not more than 200 mg percent. An occasional trace or 1+ glycosuria was present in the tested specimens. Patients classified as having fair response were those who had fasting blood sugar between 140 and 175 mg percent and postprandial blood sugar between 200 and 240 mg percent, with 1+ or 2+ glycosuria. The others were classified as failures.

Table I shows the result of treatment:

TABLE I

Results of treatment in 25 patients:

Excellent	16
Good	6
Fair	1
Failure	2

Sputum before treatment was negative in 22 and positive in three patients. During and following treatment with long-acting phenformin, the three patients who had positive sputum all converted to negative. However, two patients with negative sputum became positive. Both patients showed resistance to streptomycin, isoniazid, and PAS. Meanwhile, their diabetes remained under control throughout the study.

Serial chest roentgenograms revealed improvement of tuberculosis in ten, slight or no change in 15 patients. Eighteen patients were discharged from the hospital as inactive cases during the study. Four patients died from causes not related to diabetes, e.g., 1 with myocardial infarction, 1 with spread of previously uncontrolled tuberculosis, and 2 with cor pulmonale.

One patient developed mild tinnitus which subsided after discontinuance of phenformin, and one patient had mild gastro-intestinal bleeding from the hiatus hernia. Eight patients had surgeries, of which there were five pulmonary resections, one thoracoplasty, one colostomy and one cholecystectomy.

DISCUSSION

It has been pointed out in our previous study[1] with sulfonylureas and short-acting phenformin that these agents do not interfere with the effectiveness of antituberculous therapy, and they are effective in controlling diabetes. This also is true with long-acting phenformin. In the present study no patient showed worsening of his tuberculosis or died as the direct result of complications of diabetes. One patient, who was resistant to antituberculosis drugs, died from spread of tuberculosis even though the diabetes was controlled with phenformin throughout the study.

Those patients who exhibited failure to long-acting phenformin required increased insulin compared to pretreatment requirements. This was observed in our previous study with other hypoglycemic agents.[1] One patient developed secondary failure 6 months following discontinuation of long-acting phenformin while he was on short-acting phenformin. His insulin requirement increased from 25 units to 75 as a result, and persisted for months. By contrast, the same patient had been on short-acting phenformin for several months prior to institution of long-acting phenformin without developing failure.

Most patients responded to phenformin in a few days, but occasionally patients showed no significant response to the drug until ten days to two weeks after the treatment was started. For this reason one should avoid premature conclusion that primary failure has occured if control was not achieved in a couple of days. Furthermore, it was necessary to supplement this agent with regular insulin depending on urine and blood sugar level during this initial period. At the beginning of treatment with phenformin it seems to be safe to give NPH or Lente insulin in progressively decreasing doses to patients who have previously been on insulin. Often at the end of first or second week, insulin can be completely eliminated.

Short-acting phenformin has been known to produce gastro-intestinal symptoms which in some cases require discontinuation of the drug. These symptoms were related to dosage; the critical level for the development of these side effects being 150 to 200 mg a day in our previous study. However, in the present study none of these patients suffered from gastro-intestinal symptoms, even when a very high dose, i.e., 250 to 350 mg of long-acting phenformin was given. In one case 500 mg was used without side effects.

It was anticipated that short- and long-acting phenformins were equal in antidiabetic effect. However, when shifting from short- to long-acting phenformin, it was always necessary to increase the dose by one-third or one-half in every instance. When returning to short-acting phenformin, the former lower dosage was sufficient.

The occasional development of acetonuria in the presence of aglycosuria and normal blood sugar levels, indicating a starvation type of ketosis without acidosis, has been reported in some studies.[3, 4] In the present study no incidence of acetonuria was seen either on short- or long-acting phenformin.

The use of a combination of long-acting phenformin and insulin has been shown to be very effective in controlling diabetes. With this combination many problem diabetics were kept on lowered dose and one daily injection of insulin. The main advantage of this combination has been in brittle diabetics who have shown wide fluctuations in blood sugar levels. It has been observed that in both brittle and stable diabetics early afternoon and fasting hyperglycemias were better controlled with long-acting rather than short-acting phenformin. Thoracic or other surgery can be performed without stopping phenformin. However, it has been our policy to use regular insulin the day of surgery and for five days more, if necessary, in addition to phenformin.

SUMMARY

1. Twenty-five tuberculous diabetic patients were treated with long-acting phenformin (DBI-TD) for a period of two to six months. Twenty-two showed excellent or good responses, one fair, and two were failures.

2. After completion of treatment, all the patients were placed on short-acting phenformin for three to six months for comparison.

3. Those patients who exhibited failure to long-acting phenformin required increased insulin compared to pre-treatment requirements.

4. When shifting from short- to long-acting phenformin, it was always necessary to increase the dose by one-third or one-half; when returning to short-acting, the former dosage was sufficient.

5. No starvation type of ketosis was observed, and side effects were almost none, in spite of very high doses.

6. The use of a combination of insulin and phenformin was very effective in controlling problem diabetics.

7. Early afternoon and fasting hyperglycemias were better controlled with long-acting phenformin rather than short-acting.

8. Phenformin did not impair the healing of the tuberculous disease.

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Hypoglycorrhachia With Viral Meningitis, Probably Lymphocytic Choriomeningitis

BY JOSEPH E. KINCAID, M.D.
KALAMAZOO

ABSTRACT—In one viral meningitis, lymphocytic choriomeningitis, low spinal fluid sugars can be found in a significant percentage of cases. This exception to the general rule, that hypoglycorrhacia rules out a viral meningitis, may be due to unknown alterations in the glucose carrier transport systems operating between the blood and cerebrospinal fluid, as well as the glycolytic effect of the markedly elevated spinal fluid cell counts that can be seen with LCM meningitis.

In addition to bacterial meningitides, hypoglycorrhachia may be found with tuberculous, fungal, and luetic meningitis, meningeal sarcoidosis, meningeal carcinomatosis and sarcomatosis, and subarachnoid hemorrhage. Tuberculosis and the nonbacterial entities evoke a lymphocytic pleocytosis. A common textbook implication is that lymphocytic pleocytosis with hypoglycorrhachia rules out a viral cause for the meningitis. This case report is presented for the consideration that one viral meningitis may be associated with hypoglycorrhachia.

CASE REPORT

S. H., a 30-year-old housewife, was admitted to Borgess Hospital on June 22, 1965, with a history of backache, generalized myalgias, headache, fever, and chills beginning ten days before admission. These symptoms cleared for three to five days then starting three days before admission, fever, chills, headache, vomiting, neck stiffness, mild ataxia, mild retrobulbar aching, and blurred vision developed. Past history and environmental history were non-contributory.

Physical examination revealed a white female, alert, oriented, in no acute distress. Positive findings were rectal temperature of 102.3° F., marked nuchal rigidity, and positive Kernig's and Brudzinski's signs. The peripheral white-cell count was 7,180 with 53 percent neutrophils. Urinalysis showed a positive test for protein, 20 to 30 red cells and more than 120 white cells. Admission lumbar puncture showed cloudy cerebrospinal fluid, opening pressure, 130, protein 252 mg percent (normal up to 45 mg percent), direct smear negative, 2 red cells, 370 white cells with 4 neutrophils and the remainder being lymphocytes, chlorides 119 meq/L (normal 118-132 meq/L), glucose of 48 mg percent (normal 40-65 mg percent).

Patient was initially treated with aqueous penicillin G, chloramphenicol, and sulfisoxazole. Lumbar puncture on the second hospital day revealed 4,450 white cells with 2 percent neutrophils and 98 percent lymphocytes, the chloride was 121 meq/L, protein 465 mg percent, and glucose was 26 mg percent. Thirty-two hours after admission the temperature returned to normal. By the third hospital day the tuberculin test was positive, and repeat lumbar puncture showed opening pressure of 140, cloudy fluid, 2,435 white cells with 100 percent lymphocytes, chloride 119 meq/L, protein 415 mg percent and glucose 23 mg percent with the blood sugar being 85 mg percent.

At this point streptomycin, para-amino salicylic acid, and isoniazid were started. On the tenth hospital day all meningeal signs cleared. Repeat lumbar puncture on the 11th day showed clear fluid, white count 54 with 100 percent lymphocytes, protein 146 mg percent, chlorides 111 meq/L, and glucose 50 mg percent. All cerebrospinal fluid cultures were negative for bacteria including mycobacteria and fungi. Acute and convalescent blood samples were sent to the Michigan Department of Health, Division of Laboratories, and complement fixation titers for lymphocytic choriomeningitis showed a rise in titer from <1:8 to 1:16. These results were felt to be compatible with infection with lymphocytic choriomeningitis virus although the virus was not actually cultivated from the cerebrospinal fluid, blood, or other sources. Titers to mumps, herpes simplex, polio types I, II, and III were not significant. With this report

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the woman was taken off all medication and there has been no residua.

DISCUSSION

Hypoglycorrhachia associated with lymphocytic choriomeningitis has been reported on previous occasions. Adair, Gauld, and Smadel[1] reported 19 spinal fluid sugars below 50 mg/100 cc from 72 proven cases of lymphocytic choriomeningitis. Lewis and Utz[2] and Thiede[3] have contributed single case reports of hypoglycorrhachia in lymphocytic choriomeningitis.

Why should hypoglycorrhachia be associated with this particular virus? A common explanation for hypoglycorrhachia is the glycolytic action of the cells in the cerebrospinal fluid. Adair, *et al.*,[1] suggest that higher cerebrospinal fluid cell counts are seen in lymphocytic choriomeningitis than in other viral meningitides. So the hypoglycorrhachia seen sometimes with lymphocytic chorimeningitis may depend upon the cerebrospinal fluid cell count. However the glycolytic effect of the cells is only a partial explanation for the lowered glucose content in the cerebrospinal fluid.[4-7] A recent explanation for hypoglycorrhachia is alteration or inhibition in the glucose carrier transport systems operating between the blood and the cerebrospinal fluid.[6-7] The presence and details of such a carrier transport defect in lymphocytic choriomeningitis meningitis are not known.

SUMMARY

The occurrence of hypoglycorrhachia with a viral meningitis, probably lymphocytic choriomeningitis, is presented.

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Doctor among Early Michigan Boosters

Ever heard of Daniel Drake, M.D.?

He had an early part in the 1840's of promoting Michigan as a vacation state.

Willis F. Dunbar, Kalamazoo, tells this story in *Michigan, A History of the Wolverine State* published in 1965 by the William B. Eerdmans Publishing Company of Grand Rapids.

"As early as 1842 a prominent Cincinnati physician was directing attention to the Great Lakes area for its beneficial effects on health. After expatiating at some length on the excellence of the climate, Dr. Daniel Drake wrote that the traveler on the Great Lakes 'has then escapted from the region of miasmas, mosquitoes, congestive fevers, calomel, intermittent ague, cakes, liver diseases, jaundice, cholera morbus, dyspepsia, blue devils, and duns, on the whole of which he looks back with gay indifference, if not a feeling of good-natured contempt.'

"The physician then contrasts the typical eastern watering place where the 'eye wanders over the comingled idlers, gamblers, coquettes, and dandies,' to the experience of seeing the 'hourly unfolding of fresh aspects of nature.' After calling attention to the historic places on the Great Lakes, he continues, 'But a different inhabitant, of more interest . . . to the dyspeptic and the gourmand, is the celebrated whitefish . . . . Its flesh, which in the cold and clear waters of the lake, organized and imbued with life, is liable but to this objection — that he who tastes it once will thenceforth be unable to relish that of any other fish,' but he cautions against eating too much trout, which 'is said to produce drowsiness.'

"One of those who took Dr. Drake's advice was Horace Mann, the famous eastern educator. Writing from Mackinac Island in 1857 Mann attests to the joys of a summer vacation in Michigan: 'I never breathed such air before, and this must be some that was clear out of Eden, and did not get cursed. I sleep every night under sheet, blanket, and coverlet, and no day is too warm for smart walking and vigorous bowling. The children are crazy with animal spirits.' "

The History Of the Radical Neck Dissection

BY HARRY C. SALTZSTEIN, M.D.
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ABSTRACT—The radical neck operation was described in a masterful fashion by George Crile in 1906. In the 1920's, 1930's, radiation was the treatment of choice. Thirty years after Crile's description surgery became popular due to improvements in pre- and postoperative care. During the past 10 to 15 years, the multi-discipline approach has developed. This includes general surgeons, otolaryngologists, plastic surgeons, neurosurgeons, x-ray therapists.

The challenge today is more thorough grounding for this kind of work, and more critical long-time evaluation of one's own results.

The operation for radical neck dissection, as it is employed today, was first described by George Crile in 1906.[1]

He reported 132 cases. The last 21 had no postoperative fatalities. The incision and thoroughness of the procedure which he described leaves nothing to be desired as of today. (Figures 1 and 2). His directives were classic: Avoid blunt dissection; avoid forcible retraction and vigorous and repeated sponging; have ample operating space; keep the field free from blood, etc.

His method of handling venous hemorrhage was as follows: Raising the patient from the horizontal to the head-up inclined position makes the veins in the neck collapse. He used a pneumatic suit "inflated sufficiently to merely support the circulation of the extremities and the abdomen up to the costal arches. . . . If the pressure falls below a certain point, the pneumatic suit pressure is increased, and then after the operation it is gradually decreased, except if there is continuing oozing from the mouth." Doctor Crile continued, "In very critical cases, an assistant experienced in the use and purpose of the sphygmomanometer is placed in charge of the management of the circulation."

In the discussion a Doctor Dawbarn, of New York City, stated that ". . . by constricting the limbs at the junction of the body tightly enough to accumulate blood in them, there results partial anemia of the head and trunk, and then there is no need of the rubber suit or the posture described by Crile. Doctor Dawbarn applied boiling water, "by means of gauze wrung out of it with thick rubber gloves. The surface is blanched at once and then there is not that bleeding which ordinarily follows release of the tourniquet. If the skin and mucous membranes are avoided, the heat will never be found injurious even to delicate tissues."*

THE 1920's - 1930's

In spite of Crile's enthusiasm and his simplified method of handling shock in the operating room,

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This paper was read at the Fifth Annual Symposium at Bon Secour Hospital in Detroit.

* About this time Doctor Henry B. Orton, of Newark, New Jersey, became interested in radical surgery for malignancy of the larynx and lateral pharyngeal wall.

He was one of the first to break the continuity of the oral or pharyngeal mucous membrane and perform a radical neck dissection including the primary in the oropharynx.

He had been a pupil of Doctor Wilfred Trotter of Scotland. (Courtesy of Doctor Richard R. Royer, Detroit, Michigan.)

the radical neck dissection did not become popular for about thirty years.

The great man in cancer was James Ewing, the organizer and developer of the Memorial Hospital in New York and outhor of *the* textbook of that day entitled *Cancer*. His philosophy was that cancer should be treated by irradiation rather than by surgery.

In the 1920's and early 1930's, at Memorial Hospital in New York, "Radiation therapy was the method of election for primary lesions within the mouth; also within the pharynx and larynx. Resection of the mandible was performed mainly in cases of radiation necrosis and osteomyelitis; occasionally for tumors. Surgery in the neck was done chiefly under local anesthesia to areas underneath the mandible;" (Submaxillary, supra hyoid dissections, etc.).[2] Respiratory obstruction and asphyxia requiring emergency tracheotomy were not uncommon complications.

Francis Carter Wood, a fundamental investigator in the field of cancer, with his laboratory at Columbia-Presbyterian in New York City, told me in the early 1920's that irradiation accomplished the same obliterative endarteritis and sclerosis of tissues, no matter how the apparatus would be improved, and that cancer cells were more vulnerable than other tissues, but only by degree. Radiation sclerosis can cause hemorrhage 20 to 30 years after its application.

There was a surgeon in New York City, Doctor George Semkin, who did not believe in irradiation. He was the exponent of radical neck dissections. His radical neck dissection stated at 8:30 A.M. and lasted until 4 or 5 P.M. The anesthesia was rectal ether given before the operation. Then a small face mask was applied, and anybody who was available would pour a few drops of chloroform on the mask. More anesthesia was needed when the patient started moving or wriggling.

The only description I could make of the procedure was that it resembled an oil painting — meticulous; absolute hemostasis; the color and moisture of every tissue preserved; no adventitious tissue left; the gentlest handling of tissues, every anatomical detail exposed. One time I watched him turn back a skin flap from the midline to the back of the neck, roll it up in a gauze, then four hours later put it back. He did not need the dermatome-graft machine.

While Crile and Semkin were able to keep postoperative hemorrhage, pneumonia, and wound infection to a minimum, the rest of the profession were not.

"During the early 1930's, surgery of the head and neck was associated with the same hazards of inhalation anesthesia, uncontrollable hemorrhage, uncontrollable sepsis, as had been the surgery 100 years before." (Hayes Martin)[2]

In the late 1930's intravenous anesthesia was introduced. This avoided the aspiration hazards of inhalation anesthesia and removed the anesthetist from the surgeon's field of the mouth, allowing him to be close to the operative field. Then came the sulfa drugs, penicillin, blood bank, and electrolytes and better understanding of the cardiac status — all within a few years. Any derelict could now be rehabilitated into a physiologically sound corpus for the short time it took to recover from head and neck surgery. But that did not mean that all of the disease was removed, as might be found out six months later.

1940

By 1940 radical neck dissections could be done safely and smoothly. Surgical techniques were extended to combined excisions of primary tumors, first of the mouth and later of the hypopharynx, in continuity with neck dissection. By 1942 composite operations of this type were widely practiced.

Of all the very radical cancer operations developed in the 1940's, the radical neck dissection seems to have best stood the test of time.

Crile stated that less than 1 percent of cancer of the head and neck metastasized below the collar into distant organs. This is disputed today. Some recent figures show 20 percent and over of distant metastasis clinically diagnosed.[3] Forty to 52 percent of autopsy cases have metastasized below the clavicle. Perhaps as David M. C. Ju, of Columbia-Presbyterian Medical Center, speculated: "The palliative therapy of today tends to prolong the terminal phase of the disease, so that enough time is provided for the dissemination of local disease in the head and neck area to the general system."[3]

1950 - 1960

Like all surgical subspecialties, surgery of the head and neck developed from general surgery. The Society of Head and Neck Surgeons, which

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was established in 1950, requires Board certification in general surgery for admission as a member.

But, like so many subspecialties, it has become increasingly detailed and "compartmentalized." "Multiple disciplines" is a better term.

Hayes Martin was responsible for the first training program in head and neck surgery, started in 1942. Now many hospitals and university hospitals have them. But it is still possible to go through an entire surgical residency program of good repute without being exposed to any of these procedures.

The current surgical literature contains many very fine articles on end-result studies of selected entities in and about the mouth. Also, various refinements in technique related to different types and kinds of tumors.[4]

But there has been *no* improvement in the radical neck operation since Crile's description in 1906.

In recent years many otolaryngologists have become interested in and competent in the management of head and neck tumors especially if the growth originates in the larynx, pharynx, antrum, or post-nasal areas. Their Board certification training now includes at least a year of general surgery.

TODAY

A quick perusal of the current issues of the *Archives of Otolaryngology* and *Laryngoscope* reveals such titles as: "Carcinoma of the Salivary Glands," of the maxillary sinuses, the cribriform plate, Acoustic tumors of the ear, carotid body tumors, many case reports of rare and unusual tumors, and staging and computer coding of laryngeal carcinoma. This indicates an intense and scientific interest in tumors of the head and neck by otolaryngologists. They have their own "American Society for Head and Neck Surgery."

Likewise, the *Journal of Oral Surgery* shows much interest in malignant diseases of the mandible and tongue. The dentists are becoming adept in making prosthetic applicances. There is a training program for "maxillo-facial prosthetic dentists."

Plastic surgeons are devising new flaps for intraoral excisions, from the forehead, etc., for wide neck and mandible removal. In some institutions the head and neck surgeon does as thorough a job as he sees fit; then the plastic surgeon takes over and is responsible for the entire problem of reconstruction. The neurosurgeons are interested in posterior antrum lesions, particularly those that have spread to the base of the brain. As some of these procedures become more extensive, the vascular surgeon may be called in for replacement or by-pass of the carotid artery.

The surgeon must have good rapport with the X-ray therapist. Indications for irradiation therapy differ in different institutions, depending upon the organization or the forcefulness or experience of the men in surgery or in irradiation therapy. Modalities have improved; side effects cut down. The combined approach is more feasible today. The hazards of surgery following X-ray therapy, evaluation of the merit of pre- and postoperative X-ray treatment, are continually being submitted to statistical studies — many of which are still controversial.

And now we come to today. Who should do this radical neck surgery? What *is* "an experienced head and neck surgeon?"

As indicated, these cases are seen by different specialties. The internist, the general surgeons see the thyroid nodules; the otolaryngologist sees antrum, sinus, pharynx, larynx lesions; the dentist and oral surgeons deal daily with the mandible and the tongue.

The basic general surgery training which is required in these specialties varies, but indubitably it is improving.

I have thought that, in addition to the above formal training, one should not do radical neck surgery for cancer unless part of the responsibility was the surgeon's commitment to follow the patient indefinitely; for only by this experience can one establish his own guidelines as to the absolute value of what he has accomplished. Doing a masterful commando procedure — removing half of the mandible, or making an Andy Gump out of your patient — and then having the disease recur in the posterior pharynx, or retro-mandibular temporal region within less than six months, is *not* what the patient expected; and, in retrospect, may make you feel that there was poor preoperative selection.

Likewise, having a carcinomatous ulcer of the tongue disappear following irradiation therapy and then having incurable necrosis of the mandible to care for two years later or having the patient left with very thin, sensitive oral mucous membrane which will ulcerate following biting on dentures or hot food, etc., and will not heal for several years, if at all, raises the question in retrospect: Was that the proper treatment?

Smithwick, in his presidential address to the Society of Head and Neck Surgeons in 1965, expressed himself thus: "I plead for greater objectivity than is sometimes demonstrated by surgeons and radiotherapists in their evaluation of the effectiveness and limitations of both the calpel and the various rays and emanations in he treatment of specific tumors. It is only by bserving over a long period of time and then hrough actual experience that the reasonable decisions as to what can and cannot be accomplished y various modalities can be achieved. What one ospital may be doing, as reported in their results, oes not necessarily mean that another hospital an accomplish the same thing utilizing the same odality — surgeons and radiotherapists differ rom institution to institution."

"Lip, thyroid, salivary gland, basal cell tumors urvive five years easily. . . . But, for the remainder, the salvaged group remains in the minority. . . . There is a place for palliative radical eck surgery — but the judgment of its indication nd value takes experience."[5]

SUMMARY

The radical neck operation was described in a asterful fashion by George Crile in 1906.

During the 1920's and early 1930's radiation herapy was the procedure of choice.

In the late 1930's and early 1940's, 30 years fter Crile's description, the radical neck operation became popular, owing to improvement in pre- and postoperative care.

During the last 10 or 15 years the multidisciplines approach, with half a dozen specialties involved in the care of these patients, has come into being. We are now living through this period of confusion.

The problem today is more thorough grounding for this kind of work and more critical long-time evaluation of one's own results.

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SCIENTIFIC ARTICLE

Evaluation of the Short Child

BY GEORGE E. BACON, M.D.
ANN ARBOR

Accurate diagnosis of short stature in children may be difficult because of the multiple etiologies. The following discussion is an attempt to aid the physician in pursuing a rational course of investigation when confronted with such a problem.

Who requires evaluation?

The term dwarfism is arbitrarily applied to any child who is below the third percentile[1] (approximately −2 standard deviations) in height for his chronologic age. In general, diagnostic studies are indicated for patients in this category. This policy need not be strictly followed, however. For instance, many procedures may be deferred in a very young patient; evaluation will be facilitated at an older age, and the physician will have had an opportunity to observe the growth pattern. Observation may also be justified in the older child who is maintaining a steady growth rate near the third percentile, especially if family history of a similar growth pattern is obtained. However, even when extensive evaluation is deferred, it is imperative to rule out those conditions (e.g., hypothyroidism) in which a delay in treatment would be permanently harmful. In the majority of cases of short stature, however, immediate diagnosis is not critical from a therapeutic point of view.

Types of dwarfism

The major types of dwarfism in children are listed in Table I.

Dwarfism secondary to systemic disease (congenital heart disease, malabsorption, central nervous system disease, etc.) is usually diagnosed by the signs and symptoms of the primary defect. The exception is renal disease in which no abnormalities may be found on physical examination. There is, however, an association of congenital urinary tract defects with malformations of the external ear. In one series, 23 of 27 children with abnormal external ears were found to have urinary tract anomalies.[2]

Patients with primary skeletal abnormalities such as achondroplasia and metaphyseal dysostosis[3] can usually be recognized by the disproportionate shortness of the extremities relative to the head and trunk. Roentgenograms of the skull, hips, and

TABLE I

Major Types of Dwarfism

I. Systemic Disease (central nervous system, cardiac, pulmonary, gastro-intestinal, renal)

II. Primary Skeletal Abnormalities
    A. Chondrodystrophies (achondroplasia)
    B. Metaphyseal dysostoses
    C. Pseudo- and pseudo-pseudohypoparathyroidism

III. Primordial Dwarfism
    A. Without associated anomalies
    B. With associated anomalies

IV. Constitutional Delayed Growth and Adolescence (Delayed Maturation Syndrome)

V. Endocrinopathies
    A. Hypopituitarism
    B. Hypothyroidism

VI. Chromosomal Abnormalities
    A. Turner's syndrome

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long bones will help to confirm the clinical impression. The disproportion in pseudohypoparathyroidism and in pseudo-pseudohypoparathyroidism is less marked, although shortening of the hands and feet is characteristic. Serum calcium is low and phosphorus high in the former condition, but chemistries are normal in the latter. Shortening of the metacarpals by x-ray is diagnostically helpful in either case.

Children with primordial dwarfism, constitutional delayed growth and adolescence (delayed maturation syndrome), and hypopituitarism present a more difficult diagnostic problem because obvious distinguishing physical features are often lacking. These patients have "proportional" short stature; that is, the extremities and trunk are equally small.

No obvious endocrine or metabolic abnormality can be found in primordial dwarfs. They remain small during childhood and do not attain normal adult height, although sexual development occurs at the usual time. Cases of this type may be sporadic or familial. Included in this group is the child of short parents, whose failure to attain the third percentile in height may be attributed to his genetic background (genetic dwarfism). The diagnosis of primordial dwarfism is strongly suggested in a patient with normal skeletal maturation and a history of low birth weight relative to gestational age[4] (intrauterine growth retardation).[5]* Confusion arises because some patients who apparently have primordial dwarfism are of normal size at birth,[6] and, furthermore, many will have a retarded bone age at least during early childhood.[6, 7] In such a case, differentiation from constitutional delayed growth may ultimately depend upon long-term observation.

Although some primordial dwarfs are normal in every aspect except size, many have associated congenital anomalies. These patients can usually be identified as belonging to one of a number of well-described syndromes.[7-13] Many of these conditions are characterized by microcephaly and mental retardation and may represent variants of the same basic defect. Attaching the proper eponym to the patient is not as important as recognizing that these children belong to the major group of primordial dwarfism with associated defects and usually carry a poor prognosis in regard to growth potential.

Patients with constitutional delayed growth are usually of normal size at birth, but fall behind their contemporaries during the first few years of life. Skeletal maturation conforms more closely to height age. In the typical case a steady growth rate is maintained, although height remains below the third percentile during childhood. Sexual maturation is also delayed. The prognosis is generally good, however, since these patients are likely to have a prolonged growth period and eventually attain a satisfactory adult height.

Hypopituitary dwarfism may be difficult to differentiate from constitutional delayed growth. Some children originally diagnosed as hypopituitary dwarfs subsequently prove to be cases of constitutional delay.[14] It is now thought that hypopituitarism is one of the rarer causes of dwarfism, accounting for roughly 5 percent or less of the children with small stature.[14, 15]

These patients have normal birth weight, but growth rate tends to plateau early in life. Bone age is usually equal to or less than height age. Since deficiency of target gland hormones can rarely be demonstrated in the resting state, diagnosis depends on more elaborate studies such as the metopirone test[16, 17] or plasma human growth hormone (HGH) assay.[18]

The metopirone test lends itself to wide usage, but a normal response depends upon the presence of adrenocorticotropin (ACTH) rather than growth hormone. It is assumed that ACTH insufficiency will usually be associated with low levels of HGH. Cases in which there is an isolated deficiency of HGH, however, will not be detected by this test. The frequency with which isolated HGH deficiency occurs is not known, but it is probably the exception rather than the rule.[14] The growth hormone assay is complex and is being performed primarily in clinical research in relatively few medical centers. Both the metopirone test and the HGH assay have been recently developed, and difficulties involving proper interpretation of results still exist. In many cases the diagnosis of hypopituitary dwarfism must, therefore, be made on a tentative basis.

Hypothyroidism often is easily recognized by the characteristic facies, decreased reflex activity, and infantile skeletal proportions. In some cases, however, the changes may be much more subtle. Bone age usually is markedly retarded.[6] Diagnosis may be confirmed by protein-bound iodine (PBI) determination. More elaborate tests of thyroid function are rarely necessary for correct diagnosis. The physician should not overlook the possibility of

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* *Low birth weight infants are called premature if the gestation was abnormally short. The term intrauterine growth retardation (IUGR) is applied if the gestation was of normal duration. Many, but not all, children with IUGR are short as adults, a type of primordial dwarfism. The prognosis for ultimate height in prematurity is somewhat better.*

TABLE II

Features of Various Types of Dwarfism

Disease	Physical Examination	Laboratory Data	Comment
I. Systemic Disease	Usually recognized by characteristic features of primary defect.	Depends on organ system involved.	Physical examination may be normal in renal disease.
II. Primary Bony Abnormalities			
1. Chondrodystrophy and metaphyseal dysostoses	Disproportionate skeletal configuration.	X-rays of skull, hips, and long bones.	
2. Pseudo and pseudo-pseudohypoparathyroidism	Short hands and feet.	Serum Ca and P. X-rays of long bones.	
III. Primordial Dwarfism			
1. Without congenital defects	Proportional skeletal configuration.	Bone-age films (usually normal).	Normal sexual development.
2. With congenital defects	Usually proportional, but with associated anomalies.	Bone-age films (usually normal).	Frequent microcephaly and mental retardation. Many syndromes described.
IV. Constitutional Delayed Growth	Proportional skeletal configuration.	Bone-age films (retarded).	
V. Endocrinopathies			
1. Hypopituitarism	Proportional skeletal configuration.	Bone-age films (retarded). Metopirone test, growth hormone assay.	May be difficult to differentiate from constitutional delay.
2. Hypothyroidism	Characteristic facies, dry skin, decreased reflexes. May have infantile skeletal configuration.	Bone-age films (retarded). PBI.	
VI. Chromosomal Abnormalities			
1. Turner's syndrome	Micrognathia, Webbed neck, broad chest, etc.	Buccal Smear, chromosome count.	Short stature may be the only obvious abnormality.

hypothyroidism in any child of small stature. No disorder of growth is more easily treated, and delay in therapy may be deleterious.

A diagnosis of Turner's syndrome[19] can readily be made in the most stigmatized children with micrognathia, webbed neck, broad chest, coarctation of the aorta, and a history of edematous hands and feet at birth. However, these associated abnormalities are not always obvious, and height may be near the normal range during early childhood. The correct diagnosis is, therefore, sometimes overlooked until puberty, when the expected adolescent changes fail to occur. Skeletal maturation is usually delayed by one or two years. A buccal smear showing a negative (male) chromatin pattern is presumptive evidence of this condition, but patients with mosaicism (e.g. XO/XX) will not always be detected by this procedure. A chromosome count provides confirmation of the diagnosis. Abnormalities compatible with Turner's syndrome may also occur in the male,[20] but diagnosis is based entirely on clinical recognition since the chromosome complement is invariably normal.

The preceding discussion is summarized in Table II.

Scheme of evaluation.

Inspection and physical examination will generally suggest a tentative diagnosis of systemic disease, bony disorders with disproportionate skeletal configuration, and primordial dwarfism with associated congenital defects. Appropriate confirmatory studies can then be obtained as suggested in Table II.

More difficulty is encountered in differentiating the various forms of proportional dwarfism. Confronted with such a situation, it is suggested that roentgenograms of skull, chest, and wrists for bone age be obtained. Blood chemistries should include PBI and blood-urea nitrogen, although renal disease as a cause of short stature is unlikely if the patient is able to produce concentrated urine.[21] The degree of skeletal maturation may help to differentiate between primordial dwarfism on the one hand and constitutional delay or hypopituitarism on the other. If the bone age is normal or slightly delayed, buccal smear is indicated in females, since the usual stigmata of Turner's syndrome need not be present. If normal, a diagnosis of primordial dwarfism is justified. If retarded skeletal maturation is found and PBI is normal, the metopirone test should be performed. This usually requires hospitalization for collection of 24-hour specimens. Growth hormone assay is helpful if available. Other studies, such as the speed with which serum-free fatty acids return to normal following insulin stimulation,[22] are presently being developed, but are not in general use. Low growth-hormone levels and lack of 17-hydroxysteroid elevation in response to metopirone suggest the diagnosis of hypopituitarism. Normal values are found in constitutional delay.

This diagnostic scheme is presented diagrammatically in Table III.

Comment:

It will be noted that many diseases associated with short stature have not been specifically mentioned. These include skeletal abnormalities such as rickets and osteogenesis imperfecta, inborn errors of metabolism such as Hurler's disease, Morquio's disease, and the aminoacidurias, and chromosomal

TABLE III

Suggested Preliminary Laboratory Studies In The Child With Proportional Dwarfism and No Other Obvious Abnormality

1. PBI 2. BUN 3. X-rays A. Skull B. Chest	If *abnormal,* appropriate tentative diagnosis is made.
C. Hands and wrists	1. *Bone age normal*: probable primordial dwarfism, but buccal smear should be done in female to rule out Turner's syndrome.
	2. *Bone age retarded* (but PBI normal): do Metopirone test and HGH assay. If *normal,* probable constitutional delayed growth. If *abnormal,* probable hypopituitarism.
	3. Note: Abnormalities suggestive of Turner's syndrome, pseudohypoparathyroidism, metaphyseal dysostoses, etc., may also be detected on films of the hands and wrists.

abnormalities such as the trisomies. They were omitted because in most cases the associated defects are sufficiently prominent that growth failure is not the chief complaint.

The evaluation of the short child as suggested by the preceding discussion will not always yield a completely satisfactory diagnosis. Laboratory results may be difficult to interpret and occasionally appear to be incompatible with the clinical picture. Even such a valuable study as the determination of skeletal maturation is subject to a rather wide, normal-standard deviation: approximately six months at age three years, increasing to one year after age 10.[23] Nevertheless, judicious use of history, physical examination, and a few laboratory studies will usually define at least the major diagnostic category to which a dwarfed child belongs.

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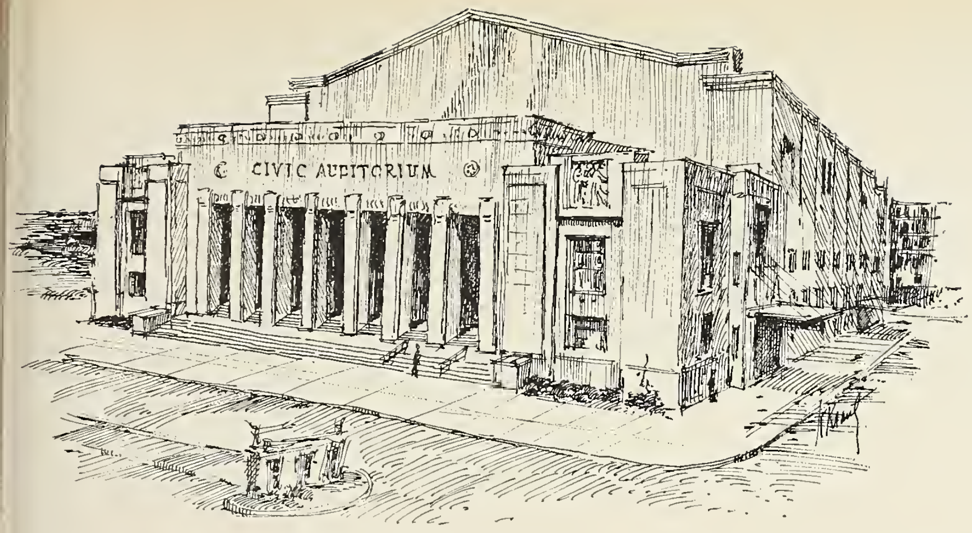


The handsome, functional Grand Rapids Civic Auditorium will be the scene of action this fall for the 1967 MSMS House of Delegates, rather than the ballroom of the Pantlind Hotel. The Black and Silver Room of the Civic Auditorium will provide better facilities and more seats for visitors.

(Sketch by Kenneth Krantz, Suttons Bay.)

Speaker Invites Every Member To See '67 House in Action

On Sunday evening, September 24, for the 102nd consecutive year, the House of Delegates of the Michigan State Medical Society will meet in convention to review the past year of dynamic activity and shape the program of a great organization for the year to come. It will be my honor for the eighth consecutive year to wield the gavel as Speaker of the House.

It will be an opportunity, as well as an obligation, for 183 Delegates and Section Delegates to participate in the deliberations. As Speaker, I wish that every member of MSMS could attend at least a part of this three-day meeting and see his House of Delegates in action.

All members are hereby cordially invited to attend the meetings of the House and any of the meetings of the reference committees.

The medical profession in the State of Michigan is governed by its members, and as a member of a county medical society, Doctor, you exercise the ultimate power in the formulation of every policy, program, and goal of your state organization.

You elect the county society officers and delegates, build its committees, determine its objectives, and carry out its plans. Your county medical society is an extension of you, yourself, multiplied for maximum effectiveness. The MSMS House of Delegates, similarly, is a composite of the 55 county medical societies of Michigan, with each of its seated Delegates selected by, speaking for, and responsible to either you personally or a group of your colleagues.

On September 24-26 *your* spokesmen will again be faced with serious and momentous decisions. The spokesmen will, as always, seek to formulate a program through which the citizens of our state may continue to receive the very best medical care and through which the physicians who provide that care may pursue their profession in freedom and with appropriate reward. The Delegates will work hard, as they always do, and their work will be fruitful.

Why not make this the year, Doctor, that you visit the MSMS House of Delegates.

I can think of nothing which will make you more enthusiastic about the Michigan State Medical Society, the profession of medicine, or democracy itself!

James J. Lightbody, M.D.
Speaker, House of Delegates

WSU Press Adds Books about Health

The newest offering from Wayne State University Press in the Lafayette Clinic Series is *Emotionally Handicapped Children and the Elementary School.* Researched in Wyandotte Public Schools by Lafayette Clinic staff and school personnel, the book is authored by Eli Z. Rubin, head of the Division of Psychology, Clyde B. Simson, chief of Children's Services, both of Lafayette Clinic, and Marcus C. Betwee, director of Special Services, Wyandotte Public Schools.

Initiated in 1965 to insure widespread discussion and dissemination of the research taking place at Lafayette Clinic, the series has already produced two other books: *Community and Schizophrenia,* by H. Warren Dunham, director of epidemiological research at the Clinic, and *Adolescents Out of Step,* by Peter G. S. Beckett, M.D., assistant director for research and chief of Adolescent Service.

"The series is intended to provide an avenue for regular publication of Lafayette Clinic research," according to Dr. Harold A. Basilius, director of the University Press. "We're quite pleased with the results so far and intend to continue the series."

Because of the success in the series of monographs, W.S.U. Press has also begun a handbook series based on Lafayette Clinic research. *Developing Ego Functions in Disturbed Children,* by Lela A. Llorens, head of the division of Occupational Therapy, and Eli Z. Rubin, is already off the press.

The second in the handbook series, planned for winter 1968, will be *Schizophrenia, Paranoid Conditions, Depression,* by Peter G. S. Beckett, M.D., and Thomas H. Bleakley, a representative for Ayerst Laboratories, Inc. The handbook will be a brief introduction to clinical psychiatry.

Another book from W.S.U. Press, though not formally in the Lafayette Clinic series, which will be of interest to physicians is *Illness or Allness,* by John M. Dorsey, M.D., formerly chairman of psychiatry at Wayne State University's School of Medicine, who at present holds the title of The University Professor.

Purified Influenza Vaccine Reported by P-D Physician

Frank B. Brandon, M.D., Senior Research Microbiologist at Parke-Davis Company, reported on clinical trials of an experimental ether-extracted influenza virus vaccine at the 67th annual meeting of the American Society for Microbiology in New York City. The technique used in the preparation of this vaccine has considerably reduced the side reactions of fever in children which has been associated with previous influenza immunization products. Doctor Brandon emphasized that this was true with both type-A and type-B strains of the influenza virus.

One study involved 122 infants and was conducted in cooperation with the Detroit Department of Health. The elimination of the febrile reaction was nearly complete when the vaccine involved only the type-A strain. When the two kinds of type-B vaccine were used, there was a considerable reduction in fever following its administration when compared to the standard vaccine.

A second study involving a large number of adults was carried out at the Henry Ford Hospital in Detroit. Doctor Brandon reported that the antigenicity of the ether-extracted vaccine, as compared with the standard influenza vaccine, was not only maintained, but actually may be an even more efficient antibody stimulator than previous vaccines.

Experimental vaccine was produced by mixing ether with an influenza virus suspension which fragments the virus. Removing the ether-soluble extraneous material leaves the fragmented virus minus the ether-soluble products. The vaccine is not yet available for wide-spread distribution.

Cooperating in the studies were Doctor Glenn O. Lease, Doctor A. E. Hook, and Doctor I. W. McLean, Jr., all of Parke-Davis; Doctor C. D. Barrett, Jr., of the Detroit Department of Health; and Doctor Edward Quinn and Doctor Frank Cox, both of Henry Ford Hospital, Detroit.

MORE AND MORE MAIL BOMBARDS THE DOCTORS

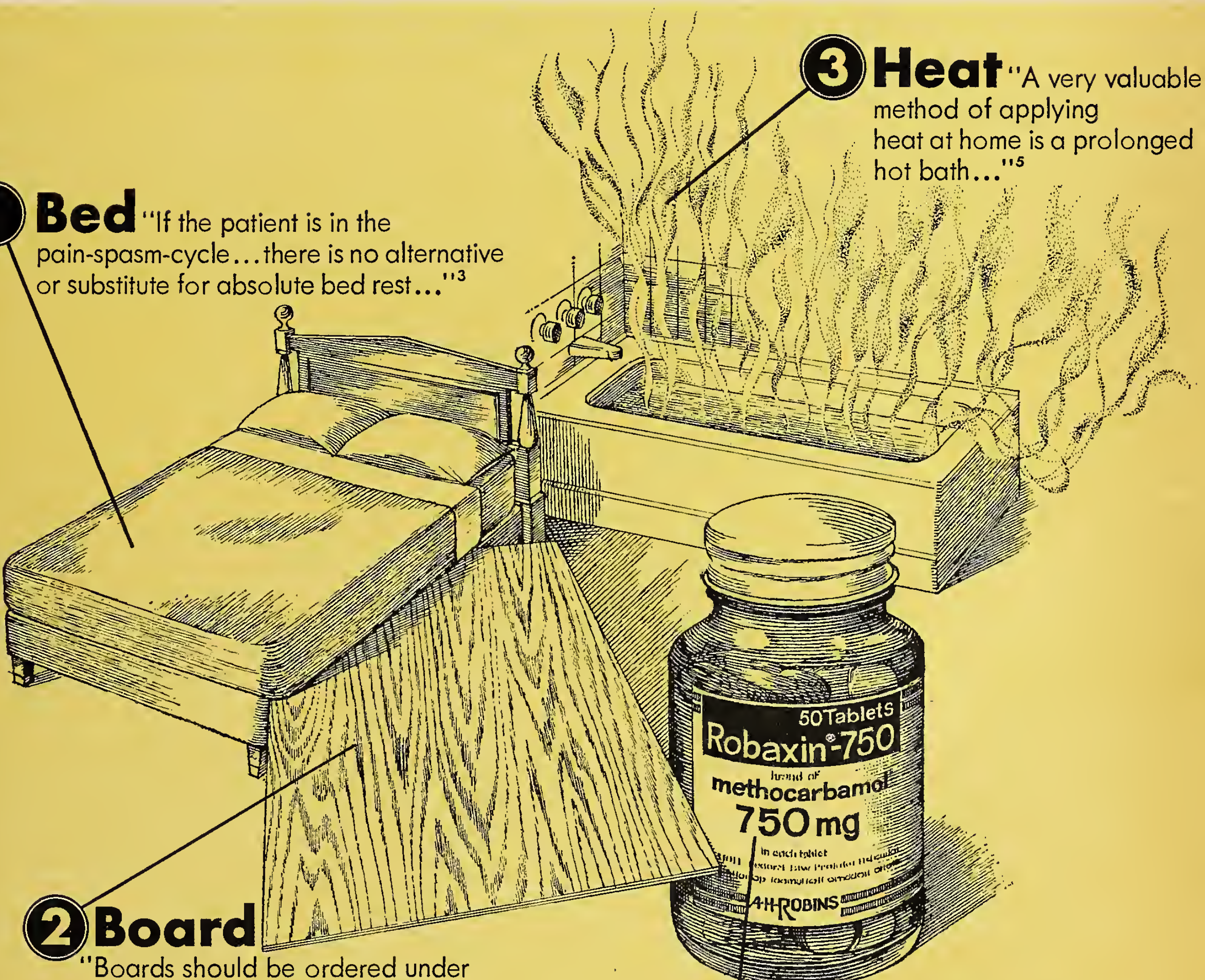
All mail to physicians increased by 2.8 percent last year and drug samples increased more than 10 percent. These figures for 1966 over 1965, according to surveys by Professional Market Research, have been carried recently in a national publication.

The national magazine, *Printers Ink,* observed that "possibly no professional group is bombarded by anything like the mass and variety of promotional materials directed at physicians."

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



① **Bed** "If the patient is in the pain-spasm-cycle... there is no alternative or substitute for absolute bed rest..."[3]

② **Board** "Boards should be ordered under the mattress... these boards act by immobilizing the spine..."[4]

③ **Heat** "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

④ **Robaxin®-750** (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

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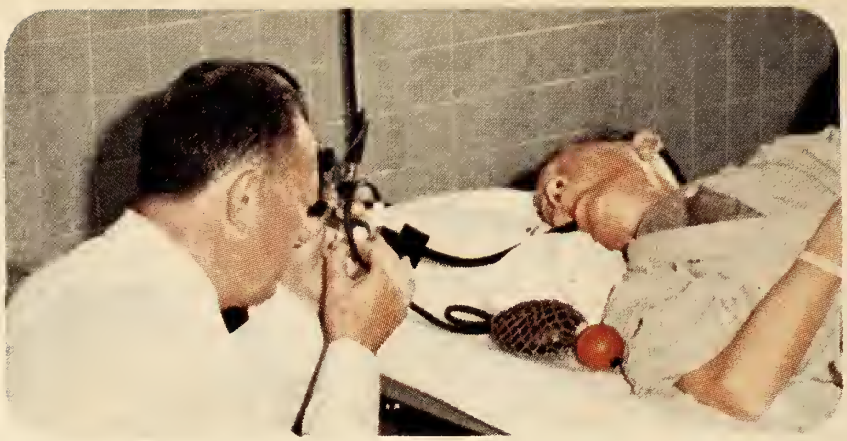
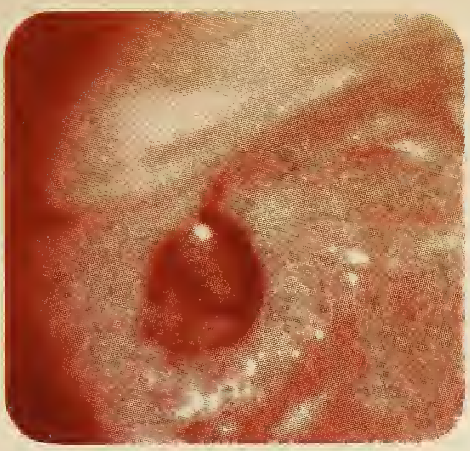


NEW EVIDENCE:

Pro-Banthīne® (propantheline bromide) **gives positive, selective benefits in gastrointestinal disorders.**



Intragastric photograph of pyloric region showing complete relaxation of pyloric sphincter with 6 mg. of Pro-Banthīne intravenously.

An important problem in managing gastrointestinal disorders has been the choice of an anticholinergic agent which will act positively and selectively on the gastrointestinal tract without extensive secondary effects.

Recent direct observations with the cinefibergastroscope and intragastric photography[1] visually confirm previous evidence that Pro-Banthīne does, indeed, possess such selective activity.

Barowsky and his associates demonstrated that a minimal dose of 6 to 8 mg. of Pro-Banthīne intravenously produced complete relaxation of gastric activity. Secondary effects were not significant.

By contrast, it required 0.8 mg. or double the usual dose of atropine intravenously to achieve similar gastric relaxation. Side effects of this dosage of the belladonna alkaloid were pronounced. Ventricular rates were as high as 150 per minute.

For positive, selective anticholinergic benefits Pro-Banthīne is indicated in patients with peptic ulcer, gastritis, irritable colon and other forms of gastrointestinal hypermotility.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Contraindications: In glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in the elderly male with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug.

Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

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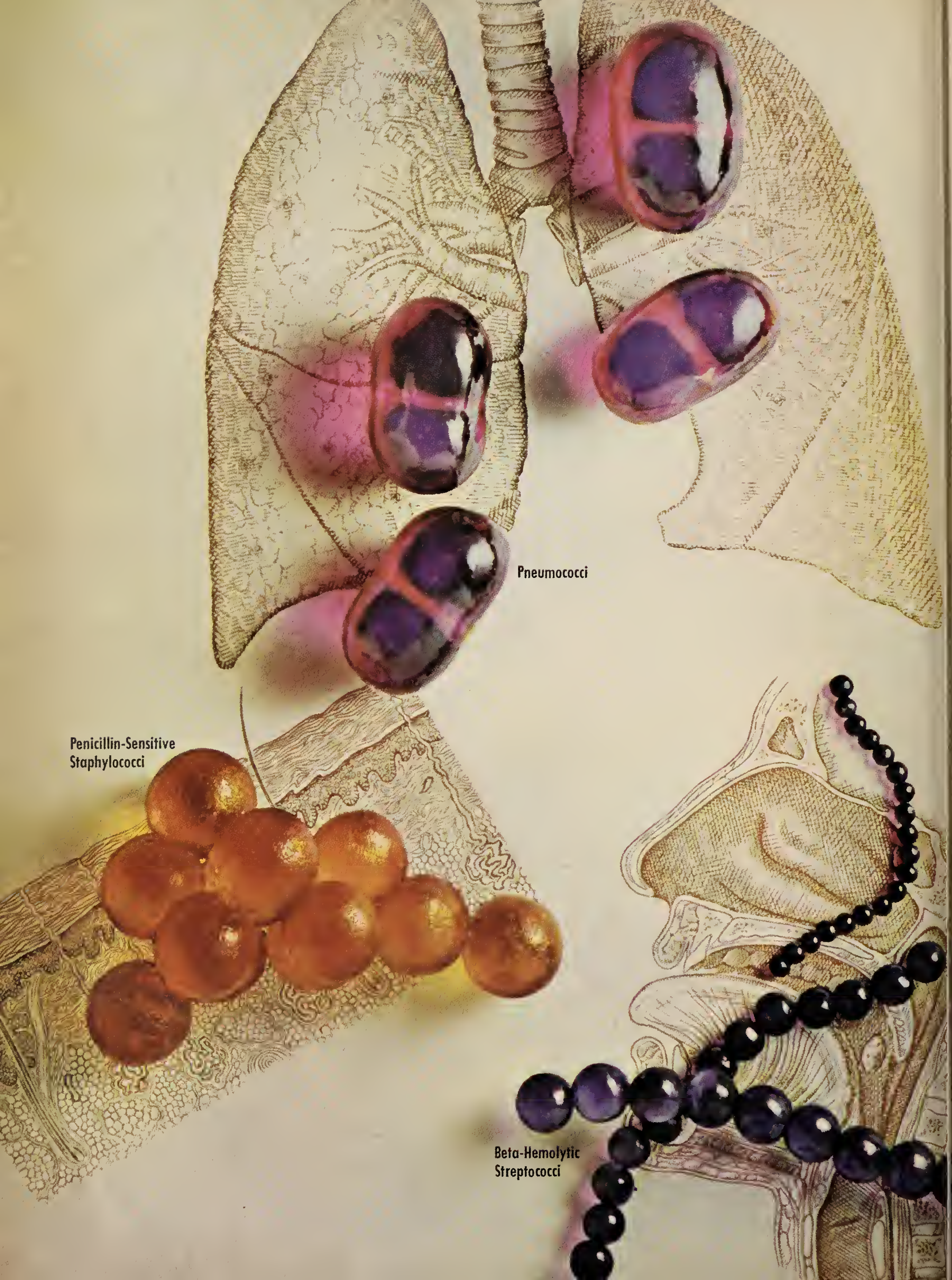
SEARLE *Research in the Service of Medicine*

Against these three major pathogens…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Penicillin-Sensitive Staphylococci
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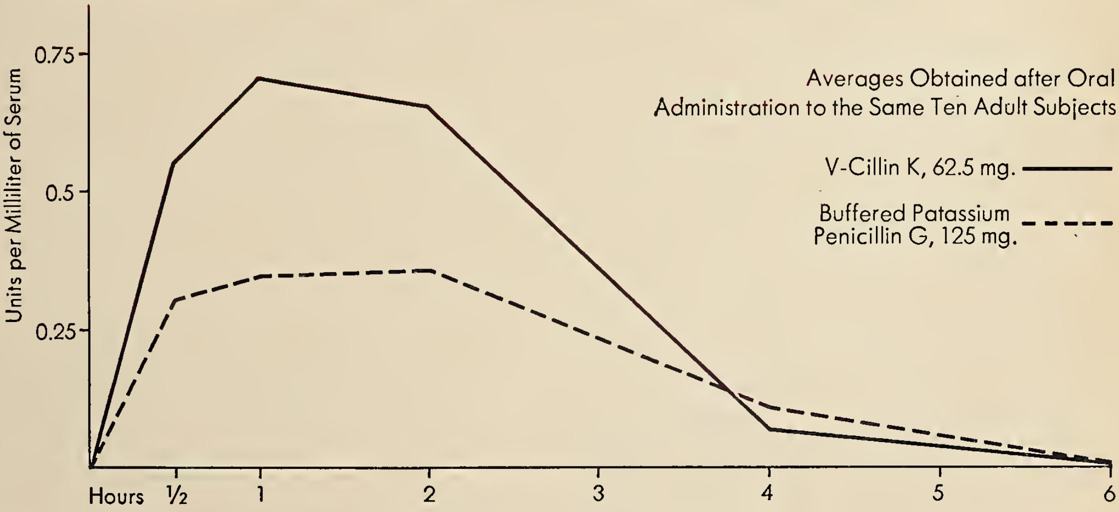
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph.Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Staph.Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Range	Streptococcus, Group A MIC (mcg./ml.) Median	Streptococcus, Group A MIC (mcg./ml.) Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Diplococcus Pneumoniae MIC (mcg./ml.) Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

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(See next page for prescribing informatio

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V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with higl parenteral dosage schedules, frequent evaluation of the renal anc hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studie (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth o pencillin-insensitive organisms. In such cases, its administration shoulc be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much les common with administration of oral penicillin than with intramuscula forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a signifi cant index of sensitization. The following hypersensitivity reaction associated with the use of penicillin have been reported: skin rashe ranging from maculopapular eruptions to exfoliative dermatitis; urti caria; and reactions resembling serum sickness, including chills, fever edema, arthralgia, and prostration. Severe and often fatal anaphylaxi has occurred (see Warnings). Hemolytic anemia, leukopenia, throm bocytopenia, and nephropathy are rarely observed side-effects anc are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K Pediatric, the usual dosage ranges from 125 mg. (200,000 units) thre times a day to 500 mg. (800,000 units) every four hours. For infants the daily dosage may be 50 mg. per Kg. of body weight divided intc three doses.

Beta-hemolytic streptococcus infections without associated bac teremia may be treated with 200,000 to 400,0000 units three times c day. Therapy should be continued for a minimum of ten days to preven development of rheumatic fever and/or other serious complications Dosage for routine streptococcus prophylaxis in patients with a histor of rheumatic fever or congenital heart disease may be 200,000 unit once or twice daily. When such patients undergo tonsillectomy, toot extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and fo two days postoperatively. If oral medication is not feasible on the da of surgery, parenteral therapy should be considered. Mild to moder ately severe pneumococcus pneumonia has been treated effectivel with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be give every six to eight hours in conjunction with indicated surgical proce dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours fo three doses may be employed; in females, 500 mg. every four hour for six doses are recommended. Refractory infections generally respon to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with c suspected lesion of syphilis should have a dark-field examination be fore receiving penicillin and monthly serologic tests for a minimum o three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), i bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 mg (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) pe 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032067

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Will the Physician Be a Leader In Modern American Society?

BY C. T. HARDWICK, Ph.D.
MSMS CONSULTING ECONOMIST

During the first half of the twentieth century, in a relatively free and independent America, the central issue facing the individual physician and even organized medicine was the advancement of scientific medicine. Through improved education and organized research the achievements in preventive and curative medicine were seemingly miraculous as compared to previous centuries. Most communicable diseases were brought under control, and improved operating techniques saved thousands of lives annually. Life expectancy was extended beyond the dreams of our great-grandfathers.

TODAY, ONE MIGHT ask if these scientific achievements were not enough to expect of physicians.

Most Americans would answer affirmatively, but would also quickly add that scientific contributions are not enough. The fact is that such achievements in scientific medicine have in themselves raised other questions concerning how all Americans can take advantage of the great science of modern medicine.

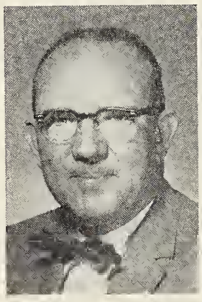
Physicians must fully realize the dynamic changes in the American environment.

In general, the age of individualism and personal scientific achievement has been fast giving way to social consciousness. The accomplishment of the expert is not enough unless his contribution is available to and shared with the masses of society. Widespread education and mass communications create an almost instantaneous want by everybody who can read about it, hear about it on radio, or see it reported on TV.

Therefore, the great scientific discoveries and physicians' improved skills immediately evoke a mass wish for cures for real or imaginary illnesses. This gives a modern dimension to medicine often labeled the socio-economic aspect. The technology and sociology of medicine are intertwined in the minds and expectations of modern American consumers.

THUS, THE PHYSICIAN finds himself inextricably involved in the socio-economic aspects of medicine such as hospital costs, insurance plans, group needs and demands, and government programs. Historically, the physician treated and dealt with the individual patient. Fees were set on a personal face-to-face basis. Resources were allocated under a relatively free market mechanism. Many services and facilities were provided on a voluntary basis. Personal relationships were maintained through good times and bad. But during the middle decades of the twentieth century, many socializing forces occurred to question and upset the old, individualized practice of medicine. Advanced scientific knowledge and technology took the most serious medical cases out of small offices and into complex hospital facilities.

Many individual physicians referred serious cases to specialists and often teams of specialists. Even the individual consumer saw advantages in joining prepaid medical group-insurance plans in order to obtain and expect the best medical care, however often or costly. Other social forces at work, such as



AUTHOR

C. T.
HARDWICK, Ph.D.

trade unions and political groups, demanded the highest level of medical care even for those who could not afford it. Now, during the second half of the twentieth century, the physician finds himself the focal point of many socio-economic forces, forces which are trying hard to change the private medical practice into a social service available to all as needed.

IS THE PHYSICIAN A LEADER OR FOLLOWER IN AMERICAN SOCIETY?

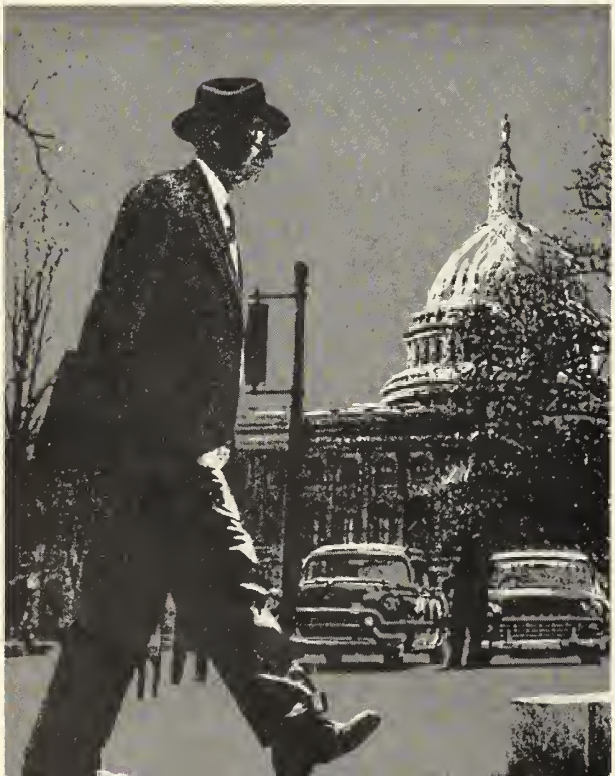
The central question in this changing environment can be stated simply: will the physician be a leader or follower?

In other words, will the physician unwillingly respond as a follower to the socio-economic forces affecting his practice, or will he be a leader in determining his role in a changing society? In terms of the social scientist, it is often said that the total citizenry or some segment of society is determined or shaped by forces such as general economic or social movements that condition and change the role of the individual.

This is now happening in the health field, social movements are afoot!

PHYSICIANS ARE faced with a critical situation in which they are confronted with an often unsympathetic, or hostile, social environment. Individually the patients want physicians' advice and assistance in regaining health, but as a whole they favor social reform often adverse to the physician.

Thus, the physician must do more than practice as a professional. He must join the social groups and affect their attitudes and value judgments toward health services. Social attitudes and programs are always in a state of flux and evolution in a dynamic society. However, development is not automatic; it depends upon suggestions, ideas, and programs of the leaders. Cultural and political norms in health fields are now under debate, and physicians' points of view are often ignored by social reformers.



SOME CONSTRUCTIVE STEPS TOWARD MEDICAL LEADERSHIP

We have argued that medicine is not practiced in a vacuum of science; rather the physician works in a changing socio-economic and political world. Medical practice is directed, affected, and modified by social movements of the welfare nature. Many groups are determined to influence it.

A physicians' destiny can no longer be considered an individual or private matter; but rather, it is a part of social dynamics. The central question is how physicians' influence can be strengthened and improved in the social movements underway.

1. Read, study, and understand current socio-economic and political propositions for change.
2. Join and assume leadership in community social and political groups.
3. Work and persuade the "opinion molders" among your patients that true progress considers the professional's individual and conservative viewpoint.

The first proposal to study and understand the contemporary issue is axiomatic. You cannot influence others until you are armed with the necessary information to support your point.

The liberals usually have the conservatives on the run because they try to defend the "status quo" without supporting data or arguments. Reading and studying will improve our defense and provide a new offense. Furthermore, when the conservative knows he is right, he should fight aggressively for what he knows to be right. Professor Milton Friedman in his book *Capitalism and Freedom* provides sound arguments even against Social Security.

In a democracy the individaul point of view gains power and influence only to the extent that members of voluntary and organized groups are convinced. Thus, the physician and his wife must use their knowledge to convert others in social, political, and religious groups.

TALKING AMONG friends who think alike is not enough. Getting into the public arena is necessary if we are to have a leadership role. This means we must take practical steps beyond our professional groupings. We cannot depend upon others to carry our message. We must become the spokesmen.

Our influence grows only to the extent that we convert outsiders to our viewpoint.

This means active roles in school groups, political parties, religious organizations, and community action programs. We cannot hope for others to speak for us because we are too busy to participate in the democratic processes. For example, the best way to influence political forces is to become an active member of a political party and work through its machinery.

THE THIRD proposal is to identify the "opinion molders" among patients.

An "opinion molder" is someone who can influence others. These generally include teachers, politicians, lawyers, and religious and business leaders. When a patient qualifies as an "opinion molder," the attending physician has the opportunity to tell him by word and action that American medicine is professionally ahead of any other available system.

Opinion molders use your treatment as the basis for a generalized statement when talking to their groups. The physician should therefore, use a little salesmanship when treating the leaders of sensitive groups. Neglect may be cited as proof of a physician's inadequacies. In contrast, attentive treatment and extra care by an attending physician speaks louder than any argument by organized medicine.

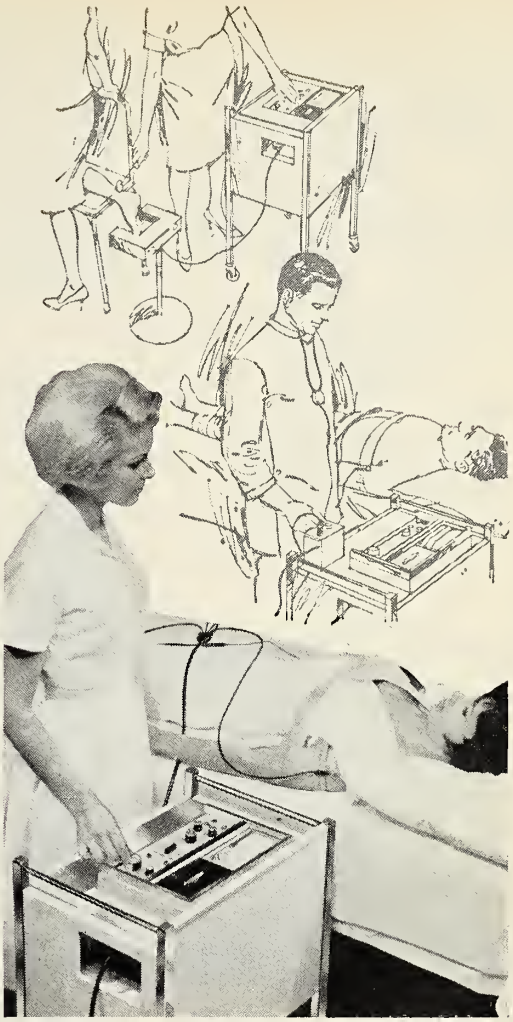
If every physician began to pay more attention to opinion molders, the positive influence of medicine would immediately improve.

CONCLUSION

The future of private medical practice is being determined in every community, city, and state of the United States right now. Only the individual physician can influence decisions about the practice of medicine. He will not be content to let others have the determining influences. No simple program can be outlined to assure success.

However, the handwriting is clear.

THE PHYSICIAN must be better prepared to discuss and argue the socio-economic questions involving the fields of health. Furthermore, he must take an active role in determining the direction of social movements. Spectators have little or no influence on the outcome of the race. Victory comes to those who run the race.



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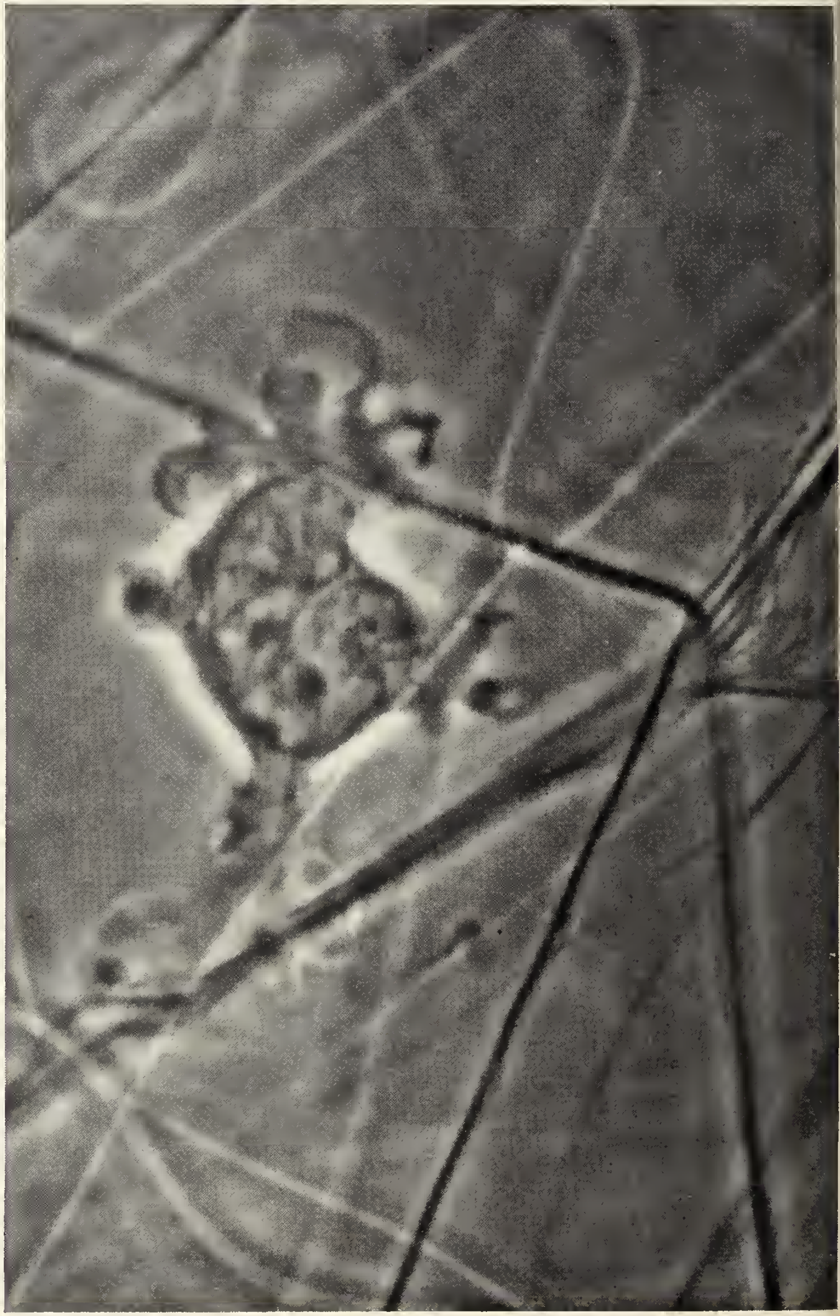
INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

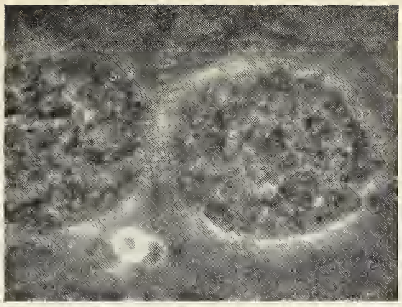


Visual evidence of how corticosteroids influence the inflammatory reaction

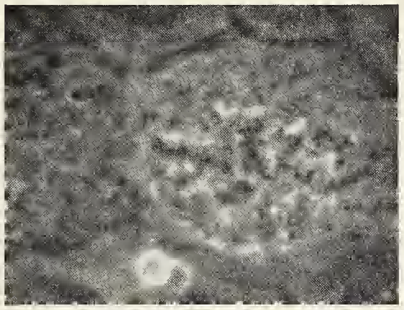
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



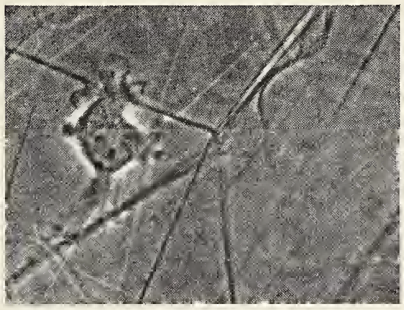
Phase-contrast microscopy showing mast cell before injury.



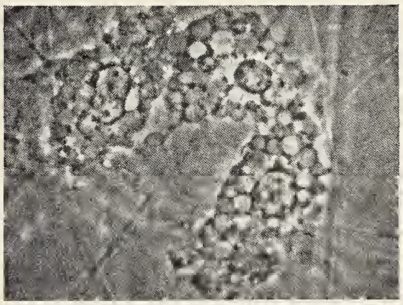
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

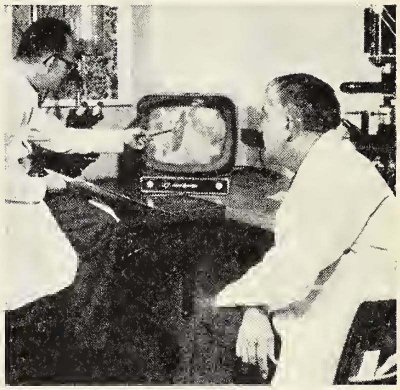
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



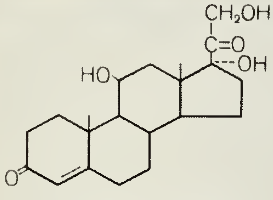
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses,* a film based on this study, is now available from your Syntex representative.

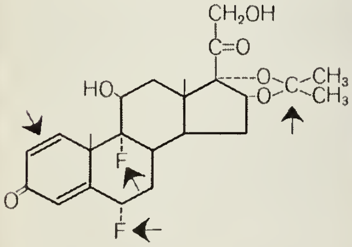
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

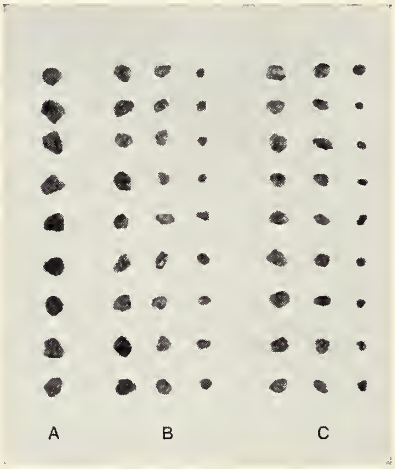


Fluocinolone Acetonide (Synalar)

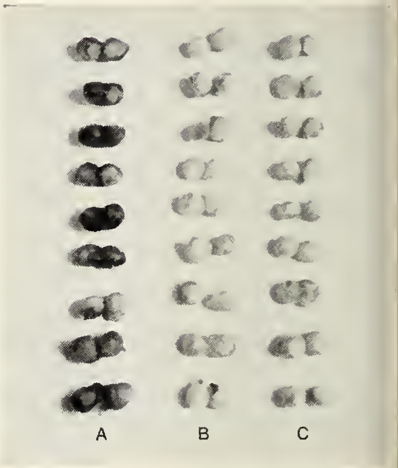
- ☐ *a double bond between carbons 1 and 2*
- ☐ *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- ☐ *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



The Thymus Involution Assay[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



The Antigranuloma Assay[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

Prescribing Information

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes. Contraindications: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. Precautions: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. Side Effects: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

References: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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viewpoints

Student Health Organizations Aid Poverty Programs

BY GEORGE H. LOWREY, M.D.
SCIENTIFIC EDITOR

Criticism of the younger generation is a sport enjoyed by nearly everybody past the age of 30 or 35. Physicians are no exception to this general rule. How often have we condemned today's medical student for his materialistic outlook and apparent lack of idealism? His exposure to an affluent society as well as the cynicism engendered by the aftermath of World War II, by Korea, Viet Nam, etc. have been blamed for the cause of his attitudes. The formation and functions of the Student Health Organization on a national level should give us cause for thought and a reappraisal of the younger generation.

The concept of the Student Health Organization was born a few years ago. There have been two or three national conventions with the election of officers, formulation of constitution, etc. Although statistics are not available for each medical school at this time, in many medical schools half or more than half of the student body have become members of this organization.

IN SOUTHERN CALIFORNIA medical students, with the help of funds from the Office of Economic Opportunity, covered pockets of poverty in nine counties including the Watts district of Los Angeles. They screened workers for disease, carried out follow-ups on patients, served as community organizers, and conducted information programs on birth control and other aspects of health. Some of the students lived in migratory labor shacks so they would be more immediately available to the people needing help.

More modest, but very worthwhile programs, are being accomplished in Michigan. Groups of student volunteers have examined indigent children going to camps sponsored by various community organizations such as the YM-YWCA. This summer they have enthusiastically participated in the Headstart program by being responsible for much of the medical program. In our own community this was done without any compensation other than the experience and satisfaction gained from it. Tuberculin tests and immunizations were completed on the children in both the camperships and the Headstart program. Adequate supervision by physicians who volunteered for the work was provided. The saving of physician man hours in the community, though difficult to estimate, is certainly considerable.

ALTHOUGH SOME MIGHT criticize this type of program because it smacks of socialized medicine and avoids the desirable contact of personal physician with a patient, one should remember that most of these children and families involved would never have received any medical aid whatsoever if such a program had not been initiated.

The experience for the medical students certainly has value. They are learning first-hand the problems of life in the poverty areas in this country. It exposes them to some of the socio-economic aspects of medicine that are difficult to attain in our present medical curriculum. Finally, it also gives them experience in how medical care can be obtained for a segment of our population that is either too poor or too ignorant to avail themselves of medical facilities.

Most encouraging is the fact that the medical students participated, not for some selfish interest or gain, but because they wanted to do something helpful for needy people. Let the older physician take another look at the youth of today before he becomes too critical. Let us also help to maintain that enthusiasm and idealism in the young physician. These qualities will be nurtured or destroyed in a large part by our example.

"Send George Washington To Viet Nam"

FROM THE ADVERTISING COUNCIL

Send George Washington to Viet Nam. Or Abraham Lincoln. Or Alexander Hamilton. Or better still, write a check.

U.S.O. needs your dollars today, for its vital work in Viet Nam. And in Korea, Okinawa, Europe and all the distant lonely places where young Americans are serving.

Wherever they go, from Arctic tundra to tropical jungle, from the overcrowded camptowns stateside to the ships at sea, U.S.O. welcomes them, serves them, entertains them. Gives them a clear choice of things to do and "the next best thing to home."

What will your dollars do? Help provide 165 U.S.O. clubs, a dozen in Viet Nam. Offering recreation, refreshment, a friendly welcome, and all kinds of services, like voice-tape letters home. Your gift will help send 91 U.S.O. shows across the world, bringing famous-name entertainment to some of the loneliest outposts on earth.

Won't you give this year through your local United Fund or Community Chest?

Someone you know needs U.S.O.

MSMS to Re-Emphasize Value of Pap Test

The MSMS Committee on Cancer has been authorized by The Council to re-emphasize the importance of the Pap smear test as an early diagnosis of cervical cancer.

The Committee, deeply concerned that so many Michigan adult females do not have an annual Pap test, has obtained permission to "urge all related health agencies, communities, physicians, nurses and hospitals to utilize whatever facilities they have to improve this situation."

Committee Chairman M. E. Dodds, M.D., pointed out to The Council, "that physicians should be aware of the importance of this test and that they should do this test on their adult women patients."

MSMS efforts also will seek to educate Michigan women to ask their physicians for the test.

Seven Colleges to Hear AMA Nutrition Lectures

Lectures on clinical nutrition will be given this fall at seven Michigan colleges by the AMA Council on Foods and Nutrition, under the co-sponsorship of MSMS.

The lectures will be given at Albion, Calvin, Hope, Ferris State, Central Michigan, Northern Michigan and Western Michigan.

The county societies serving the college towns will be invited to serve as co-sponsors.

Initiated in 1965 on a regional basis, the AMA in 1967 will serve Michigan and 10 other states.

The lectures by distinguished scientists will tell students and faculty about recent developments in human nutrition.

Come Watch MSMS Delegates

Members of the Michigan State Medical Society are invited to attend the sessions of the MSMS House of Delegates and also meetings of the reference committees.

The House of Delegates will meet three days in five sessions during the Annual Session: Sunday, September 24, 8:00 p.m.; Monday, September 25, 8:30 a.m. and 8:00 p.m.; Tuesday, September 26, 8:30 a.m. and 8:00 p.m.

All meetings of the House will be in the Black and Silver Room of the Civic Auditorium, and not in the Pantlind Hotel this year.

Locations for reference committee meetings will be published in the Annual Session Program; times for the meetings will be announced at the House of Delegates sessions.

Careers Mobile At Ionia Fair

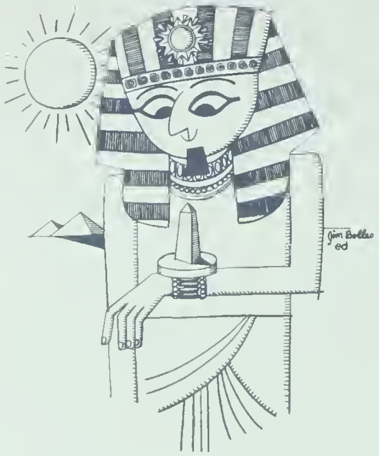
Don't miss a chance to see the Health Careers Mobile as it tours your community. It is a wonderful opportunity for physicians as well as laymen to learn more about Michigan's medical history and about the educational facilities for health personnel in this state. One time that physicians will have a prime opportunity to visit the Careers Mobile will be at the MSMS Annual Session in Grand Rapids.

Too, physicians can urge young persons interested in health careers to visit the 50-foot coach to learn more about the professions in the health field.

Included in the recently updated exhibits are special displays prepared by the medical schools — the University of Michigan, Wayne State University, and Michigan State University. Too, there is a heart-lung machine used in open-heart surgery, and the machine itself was built by the Sarns Company in Ann Arbor.

The Health Careers Mobile will be in Ionia at the Free Fair, August 4-12. Next stop will be the County Fair at Midland, August 14-19. Then the Mobile travels to the State Fair in Detroit, August 19-24.

The schedule for the remainder of the autumn is: Allegan, September 9-16; Grand Rapids, September 22-29; Battle Creek, for Community Health Week, October 15-19; Detroit, for the Youth Health Conference on "Health Careers," October 20. During November the Mobile will be visiting various junior and senior high schools in the Detroit area.



Yes, everyone is checking his clock and calendar.

Yes, physicians and wives alike are asking about the MSMS Annual Session State Society Dinner Dance.

When will it be?

The 1967 gala dinner dance will be held on Wednesday evening, September 27, in the Grand Ballroom of the Pantlind Hotel, Grand Rapids.

Mark the date down now. Details will follow.

Drug Dependency Consultation Offered By MSMS Committee

Consultative services are offered by the MSMS Committee on Alcoholism and Drug Addiction to MSMS members.

The Committee had requested The Council that it "be empowered or directed to serve as a consultative group to MSMS members in any problem that physicians might have in the area of drug dependency."

The Council approved the Committee recommendation.

Requests should be directed to the Chairman, C. K. Stroup, M.D., Committee on Alcoholism and Drug Addiction, MSMS, 120 West Saginaw, East Lansing, Michigan 48823.

AMA Delegates Re-Elect Slagle; Salute U-M

George W. Slagle, M.D., a MSMS Past President, was elected by the AMA convention to a second five-year term on the AMA Council on Medical Service. The Battle Creek medical statesman was unopposed as a second nominee withdrew from the race. Doctor Slagle will continue as the Council chairman.

The AMA convention at Atlantic City saluted the University of Michigan for "150 years of exemplary service" as the delegates adopted a MSMS resolution. The 1966 MSMS House of Delegates had authorized such a resolution to cite the University and its Medical School.

The Michigan delegation members, led by Luther R. Leader, M.D.; Royal Oak, were very active attending reference committees, speaking to resolutions from the floor, and carrying out many other responsibilities.

(A detailed article about MSMS members who spoke and exhibited at the Atlantic City convention will appear in the August issue.)

USA, Mexico Change Vaccination Ruling

MSMS members now may advise their patients that travelers between the United States and Mexico are no longer required to present a smallpox vaccination certificate provided they have visited no other countries within 14 days prior to crossing the border. The final action on this new regulation, announced by officials of the United States and Mexican governments, went into effect June 17.

RECOMMENDED SCHEDULE FOR THE TREATMENT OF SYPHILIS, GONORRHEA, CHANCROID, LYMPHOGRANULOMA VENEREUM, AND GRANULOMA INGUINALE

Effective January 1967

MICHIGAN DEPARTMENT OF PUBLIC HEALTH
DIVISION OF ADULT HEALTH

PRIMARY AND SECONDARY SYPHILIS:

A. Aqueous procaine penicillin G - 600,000 units daily for 8 days (total 4,800,000 units).

B. Procaine penicillin in oil with aluminum monostearate (PAM) - 4,800,000 units total; 2,400,000 units first session and 1,200,000 units at two consecutive injections three days apart.

C. Benzathine penicillin G (Permapen or Bicillin) - 3,600,000 units total; 1,200,000 units in each buttock by intramuscular injection followed by a third injection of 1,200,000 units one week later.

PROPHYLACTIC (PREVENTIVE) TREATMENT:

The contacts of a person diagnosed as having primary or secondary (lesion) syphilis should have a complete physical examination including serologic tests for syphilis. Even though such examination may show no signs or symptoms of the disease and if the patient has been exposed within 60 days, preventive treatment is recommended at the time the blood test is done. For preventive treatment 2,400,000 units of benzathine penicillin G should be given. It is well known that a significant proportion of contacts to primary and secondary syphilis will develop clinical evidence of the disease and may infect additional persons if prophylactic treatment is not given.

LATENT SYPHILIS:

If a spinal fluid examination is performed, the treatment for latent syphilis is identical to that identified above for primary and secondary. If, however, no spinal fluid examination is performed, the possibility that the patient has asymptomatic neurosyphilis must be considered and treatment should be given to cover this possibility. Treatment then becomes the same as that given for neurosyphilis reported below.

LATE SYPHILIS:

Asymptomatic neurosyphilis
Symptomatic neurosyphilis
Cardiovascular syphilis
Late benign (cutaneous, osseous, and visceral gumma) syphilis

A. Aqueous procaine penicillin G - 6 to 9 million units total, giving 600,000 units daily.

(Continued)

B. Procaine penicillin in oil with aluminum monostearate (PAM) - 6 to 9 million units total, giving 1,200,000 units at three day intervals.

C. Benzathine penicillin G (Permapen or Bicillin) - 6 to 9 million units total, giving 3 million units at seven day intervals.

SYPHILIS IN PREGNANCY:

In general, the therapy is the same as for primary and secondary syphilis, but dependent upon the stage in which the diagnosis is made. If the woman is in labor, evaluation of the mother and the newborn can be made after delivery. However, if the woman has primary or secondary syphilis, treatment should be begun as soon as the diagnosis is made. Treatment will not completely prevent the stigmata of congenital syphilis unless it is given before the fourth month of pregnancy. Whenever possible a quantitative serologic test should be obtained in each trimester of pregnancy. Frequently the question arises as to whether a woman who has acquired syphilis should be retreated during each pregnancy. In general, if she has been adequately treated before and there is no evidence of relapse or reinfection, additional therapy is not necessary. However, if there is a question of the adequacy of previous treatment, or of the patient remaining under close observation, or if there is evidence of relapse or reinfection, retreatment should be given.

Persons allergic to penicillin:

The treatment is the same as other schedules listed for early and latent syphilis except that treatment must be given over a 15 day minimum period. Following this there should be very careful follow-up of the infant with serologic tests for syphilis as well as clinical examinations to determine the presence or absence of congenital syphilis.

CONGENITAL SYPHILIS:

1. *Early Congenital Syphilis*

   A. Aqueous procaine penicillin G - 100,000 units per kilogram of body weight divided into daily dosage over a 10 day period. Total dosage should not exceed 5 to 6 million units.

   B. Benzathine penicillin G (Permapen or Bicillin) - 50,000 units per kilogram of body weight at one visit. Total dosage should not exceed 5 to 6 million units.

2. *Late Congenital Syphilis*

   If the spinal fluid is non-reactive, treatment is the same as latent syphilis. Certain problems of late congenital syphilis such as eighth nerve deafness and interstitial keratitis represent special treatment problems and are not amenable to penicillin therapy.

PERSONS ALLERGIC TO PENICILLIN:

For those individuals with syphilis who cannot take penicillin because of hypersensitivity, the alternate antibiotics of choice in the treatment of *early* syphilis are:

A. Erythromycin - 3 grams daily for 30 - 45 grams total over 10 - 15 days.

B. Tetracyclines - 30 - 40 grams over a 10 - 15 day period.

For *other* stages of syphilis:

A. Erythromycin stearate - a minimum of 45 grams administered over a period of 15 days.

B. Tetracyclines - 45 grams administered over a period of 15 days.

GONORRHEA:

The treatment of gonorrhea is in a state of uncertainty although penicillin still remains the drug of choice. Some strains of the gonococcus are developing increasing resistance to penicillin, but this resistance is relative and not absolute. As a result it is necessary to recommend on an interim basis short acting penicillin preparations in larger doses. Treatment schedules are presently being evaluated and until results are available the following are recommended:

Uncomplicated gonorrhea in men: aqueous procaine penicillin G - 2,400,000 units in one intramuscular injection.

Uncomplicated gonorrhea in women: aqueous procaine penicillin G - 4,800,000 units intramuscularly in two injection sites at one visit, or the combination of equal parts of (1) aqueous procaine penicillin G and (2) procaine penicillin G in oil with 2 percent aluminum monostearate for two separate intramuscular injections of 2,400,000 units in each site given at one visit.

Prophylactic or preventive treatment for gonorrhea (male and female) is accomplished with the same treatment schedules as for uncomplicated gonorrhea.

Complications and Retreatment:

Treatment of gonorrhea with severe complications must be individualized using large amounts of short acting penicillin.

Excluding the likelihood of reinfection, retreatment is indicated if the discharge in uncomplicated gonorrhea in the male persists for three or more days following initial therapy and the smear, F.A., or culture is still positive. In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cultures or F.A. procedures remain positive for gonococci. Retreatment consists of doubling the original dosage at a single visit or in divided doses on two successive days.

Penicillin Sensitivity:

Gonorrhea patients sensitive to penicillin may be treated effectively with tetracycline, erythromycin, or oleandomycin. These may be administered as a single oral dose of 1.5 grams or 0.5 grams given orally every 4 - 6 hours until 2 - 3 grams have been given.

Serologic Tests for Syphilis:

Since the effects of these dosages of penicillin or broad spectrum antibiotics on possible co-existent incubating syphilis are unknown, all gonorrhea patients should be followed with serologic tests monthly for four months to detect syphilis that may have been masked by antibiotic therapy.

Gonorrhea patients who are sexual contacts of infectious syphilis should be given full prophylactic therapy for syphilis (2,400,000 units of benzathine penicillin) as well as recommended therapy for gonorrhea.

While long acting forms of penicillin (such as benzathine penicillin G) are ideal in syphilotherapy, they are not indicated in routine gonorrhea treatment.

CHANCROID:

A. Sulfonamides - 4 grams daily in divided doses for 10 - 14 days.

B. Tetracyclines - 500 milligrams every 6 hours for 10 days.

C. Streptomycin - 1 gram every 6 hours for 5 days.

In more severe cases a daily 1 gram injection of Streptomycin may be added to the sulfonamides for more prompt response.

GRANULOMA INGUINALE:

A. Tetracyclines - 500 milligrams every 6 hours for 12 - 14 days. The antibiotic may have to be continued for a month or more in cases which respond slowly. Treatment should extend 7 days beyond clinical cure to aid in preventing relapse.

B. Streptomycin - 1 gram every 6 hours for 5 - 15 days.

LYMPHOGRANULOMA VENEREUM:

A. Tetracyclines - 500 milligrams every 6 hours for 10 - 14 days.

B. Sulfonamides - 4 grams daily in divided doses for 10 - 14 days.

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Michigan Legislators Urge Doctors Offer "Proposition," Not "Opposition"

"Medicine must be positive and imaginative in preparing alternaives and proposals on health care issues."

That general statement was made by two Michigan senators who spoke to The MSMS Council at its July meeting.

Michigan needs to offer "proposition" rather than "opposition," stressed Senator Robert VanderLaan of Kent County. He also suggested that county medical society legislative committees should meet monthly with the local legislators. He lauded the ongoing program of the Kent County Medical Society.

"Physicians and legislators need to increase and improve communication with detailed exploration of issues," declared Senator Sander Levin of Oakland County. He recommended that physicians keep contact through face-to-face meetings, through letters and telephone calls.

Senator VanderLaan is the majority floor leader and Senator Levin floor leader for the minority in the Michigan Senate.

Michigan Foundation Aids Hospitals

Annual grants to the University of Michigan and the Central Hospital Council of Saginaw were announced at the recent meeting of the Michigan Foundation for Medical and Health Education continuing its financial support in the field of medical education.

The Foundation issued its annual $150 grant to maintain current books and medical journals at three Saginaw hospitals. In addition, it gave over 3,700 dollars to the University of Michigan Board of Regents for use by the medical school to support pediatric residencies.

Recently, the Foundation gave other grants such as $1,000 to the Michigan Health Council for Health Careers recruitment, $300 training grants to physicians attending alcoholism seminars, plus scholarship grants to Wayne and University of Michigan and loans to medical students.

See September Issue For Riot Sidelights

The presses were rolling for the August issue of *Michigan Medicine* when the costliest riot in the nation's history hit the Detroit area on July 24.

See the September issue for related articles.

Blue Shield Plans Research Study

Michigan Blue Shield will undertake an extensive research project relating to the use and cost of medical care in Michigan.

John C. McCabe, Blue Shield president, explained the project will require at least one year's work and cost an estimated $100,000.

John M. Wellman, M.D., Lansing, Chairman of the Blue Shield Board, said that a special board committee headed by Robert Stow, M.D., East Lansing, will regularly review progress reports as the study develops.

FORD IS COMING — The physicians chatting in Washington, D.C., with Congressman Gerald Ford are arranging for him to speak at the MDPAC Breakfast, September 27 at 7:30 during the MSMS Annual Session in Grand Rapids. From left to right they are: Donato Sarapo, M.D., Adrian; Vernon V. Bass, M.D., Saginaw; Thomas R. Berglund, M.D., Kalamazoo; Congressman Ford; Everette Gustafson, M.D., Pontiac; and R. J. Fisher, M.D., Ypsilanti.

Inter-Specialty Committee Under Study by Council

The MSMS Council has approved plans of the new committee to study the feasibility of establishing an inter-specialty committee to continue its deliberations.

The MSMS Council members approved Committee minutes, which contained the following points:

"1. Specialty groups are increasing in number and in size. Many of them are attempting their own lobbying efforts, sometimes without success because they often do not have the benefit of an over-all view. Frequently they do not have the advantage of adequate staff assistance. Occasionally, the separate efforts of such groups may be divisive in the ranks of medicine.

"2. MSMS should get closer to specialty groups; offer coordinating assistance. Perhaps it would be possible to supply executive secretary services to them.

"3. MSMS should emphasize cooperation in socio-economic problems; a side benefit might be better coordinated post-graduate educational programs.

"4. Such a program would be the beginning of medical ecology."

Louis F. Hayes, M.D., Gaylord, Vice-Speaker of the MSMS House of Delegates, is the Committee Chairman.

Would Check Medicare

"Voluntary health insurance should be encouraged. Legislation for compulsory medical and hospital insurance should not be extended."

That is a digest of the policy declaration on health insurance taken at the 55th Annual Meeting of the Chamber of Commerce of the United States.

MSMS is a member of the U.S. Chamber.

Surgeons Elect; Award To Kline

The Frederick A. Coller Award, given annually by the Michigan Chapter of the American College of Surgeons, was won this year by David G. Kline, M.D., of the University of Michigan Medical Center. The presentation was a highlight of the recent annual meeting of the Michigan Chapter.

Doctor Kline competed with 19 interns and residents from Michigan hospitals for the Award. His winning presentation was entitled "Experimental and Clinical Studies of Peripheral Nerve Injury: In Vivo Recording of Evoked Potentials."

Installed as president of the Chapter was Robert E. L. Berry, M.D., Flint. Other officers include: President-Elect William S. Carpenter, M.D., Detroit and Secretary-Treasurer Roger Smith, M.D., Detroit, who was re-elected. Frederick Gillette, M.D., Grand Rapids, was elected councillor for three years.

Diet Therapy Conference to Cover Alcoholism, Kidney Diseases, Aging

Alcoholism, kidney diseases, and gerontology will be the main topics at the two-day Diet Therapy Conference during the MSMS Annual Session.

Designed for physicians and other professional personnel concerned with therepeutic dietary management, counselling, and teaching of professional staff, patients, and their families, the Conference is cosponsored by MSMS and the Nutrition Section of the Michigan Department of Public Health.

The program includes: *Alcoholism*: Wednesday, September 27. "Review of Literature," by Olaf Mickelsen, Ph.D., Michigan State University; "Metabolism and Caloric Value of Alcohol," by Wilfred W. Westerfield, Ph.D., Department of Biochemistry, College of Medicine, Upstate Medical Center of the State University of New York, Syracuse.

Kidney Diseases: Wednesday, September 27. "Physiology of the Normal Kidney," by William Oliver, M.D., University of Michigan Medical Center; "The Modified Terminal Renal Syndrome," by George L. Bailey, M.D., Peter Bent Brigham Hospital, Boston; "Diet Therapy," by a Henry Ford Hospital dietician.

Gerontology: Thursday, September 28. "Biological and Physiological Changes as Related to Aging," by Charles Barrows, M.D., Department of Health, Education and Welfare, Gerontological Research Center, Baltimore City Hospitals; "Effect of Nutrition on Life Span and Age Related Diseases," by Morris Ross, M.D., Institute for Cancer Research, Newark, Deleware; "New Thoughts on Old Age," Robert Kastenbaum, Ph.D., Director, Psychological Research, Cushing Hospital, Framingham, Mass.; "Human Nutrition Studies as Related to Age," by Robert McGandy, Ph.D., Department of Nutrition, Harvard School of Public Health, Boston; "Osteoporrosis — A Unified Concept," by Robert P. Heaney, M.D., Department of Medicine, Creighton University School of Medicine, Omaha.

Several Michigan physicians were reelected to four-year terms on school boards for Oakland and Wayne Counties.

In Oakland County Charles L. Bowers, M.D., Bloomfield Hills, was unopposed, and Charles A. Leach, M.D., was reelected from Birmingham.

Again serving as a Taylor Township school board member is Wesley B. Mikesell, Jr., M.D.

Newly elected to the board of directors of the Ingham County Chapter of the Michigan Society for Mental Health were Andrew D. Hunt, M.D., Dean of the College of Human Medicine of Michigan State University, and Arthur L. Stanley,M.D., Director of Ingham Medical Hospital.

The new chairman of the Women's Division of the Safety Council of Greater Lansing is Fanny H. Kenyon, M.D. Doctor Kenyon was installed at the recent annual meeting of the board of directors.

Michael J. Brennan, M.D., Detroit, President of the Michigan Cancer Foundation, has been named chairman of the Detroit Archdiocesan Synod Commission on the Laity. Doctor Brennan, Associate Professor of Medicine at Wayne State University, was president of the Catholic Physicians' Guild in 1962.

Robert M. Rees, M.D., former resident in neurology and internal medicine at the University Hospital in Ann Arbor, has been appointed vice president of clinical research at Winthrop Laboratories.

Doctor Rees was previously director of medical research for Winthrop Products, Inc., a Sterling subsidiary in overseas trade.

about doctors and their friends

Theodore G. Klumpp, M.D., is marking his 25th anniversary as president of Winthrop Laboratories, the pharmaceutical manufacturing division of Sterling Drug, Inc.

Doctor Klumpp, a graduate of Harvard Medical School, spoke at an MSMS meeting several years ago in Detroit.

Two faculty members received awards at the University of Michigan Medical School's 1967 Class Day Ceremony and Honors Convocation. Richard O. Kraft, M.D., Clinical Assistant Professor of Surgery, received the Senior Award as the junior faculty member judged by the senior class as the most outstanding clinical teacher. Charles L. Votaw, M.D., Associate Professor of Anatomy, was given the Elizabeth C. Crosby Award as the "most outstanding teacher in the basic sciences."

Irvin J. Martens, M.D., Kalamazoo, Director of Medical Education at Borgess Hospital for the past 13 years, has moved to the Los Angeles area to open private practice in surgery.

C. S. Emery, M.D., St. Joseph, has retired after 38 years of practice. He announced his retirement on his 73rd birthday.

Another Michigan physician who recently retired is W. B. Bloemendahl, M.D., Grand Haven physician for 40 years.

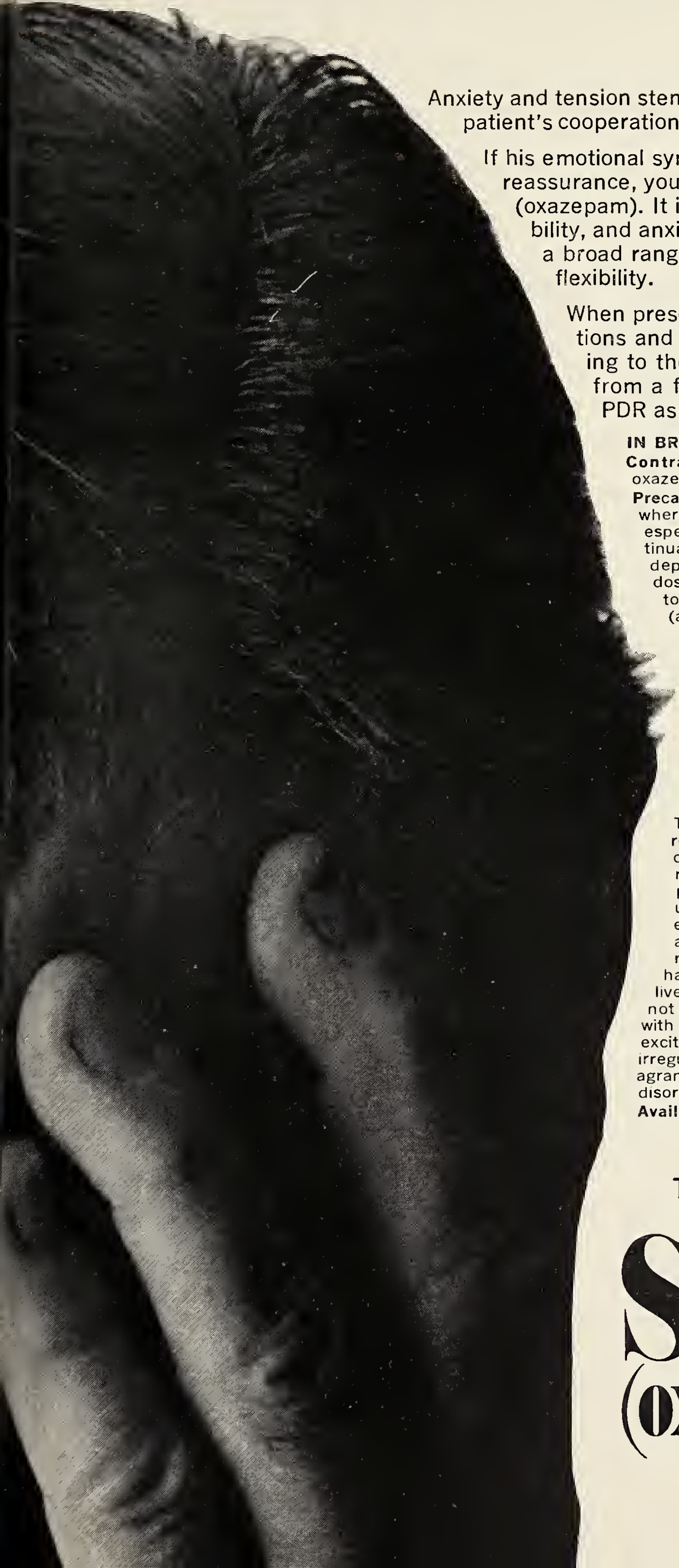
The new chief of the Division of Maternal Health, Bureau of Maternal and Child Health of the Michigan Department of Public Health, is Harold A. Ott, M.D., East Lansing. Doctor Ott was previously a member of the faculty of Wayne State University School of Medicine.

Richard J. Lilly, M.D., has joined the staff of Haven Hospital and Psychiatric Center in Rochester as a full-time psychiatrist. Doctor Lilly was formerly assistant superintendent of Northville State Hospital.

Richard W. Pomeroy, M.D., Lansing, has accepted new positions as Director of Medical Education at Edward W. Sparrow Hospital and as a member of the faculty at Michigan State University. Doctor Pomeroy has limited his practice to crippled children at Sparrow Hospital though he continues his work at the Rehabilitation Medical Center.

Sick, and worried sick

Professionally posed



Anxiety and tension stemming from organic illness may undermine your patient's cooperation and possibly retard success of primary therapy.

If his emotional symptoms persist in the face of your counsel and reassurance, you may want to consider adjunctive use of SERAX (oxazepam). It is indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression. May be used in a broad range of patients, usually with considerable dosage flexibility.

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly and when complications could ensue from a fall in blood pressure. (See Wyeth literature or PDR as well as "IN BRIEF" below.)

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10,15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

Serax®
(oxazepam)

Wyeth®
SERVICE
TO
MEDICINE

Wyeth Laboratories
Philadelphia, Pa.

ORDER OF BUSINESS FOR 1967 MSMS HOUSE OF DELEGATES

SUNDAY, SEPTEMBER 24

Black and Silver Ballroom
Civic Auditorium, Grand Rapids

6:00 p.m.—REGISTRATION

8:00 p.m.—FIRST MEETING

1. Call to Order by Speaker
2. Invocation
3. Report of Committee on Credentials
4. Appointment of Reference Committees
5. Speaker's Remarks—J. J. Lightbody, M.D., Detroit
6. ADDRESS: Hon. Dwight L. Wilbur, M.D., President, American Medical Association
7. Reports of House of Delegates Committees on Certificates of Commendation and Michigan's Outstanding Physician
8. Introduction of Resolutions

* * *

MONDAY, SEPTEMBER 25

8:30 a.m.—SECOND MEETING

9. Supplemental Report of Committee on Credentials
10. Report of Committee on Rules and Order of Business
11. President's Address—C. Allen Payne, M.D., Grand Rapids
12. President-Elect's Address: Bradley M. Harris, M.D., Ypsilanti
13. Greetings from the Woman's Auxiliary: Mrs. Henry Scovill, Ypsilanti
14. Greetings from the Michigan State Medical Assistants Society: Mrs. Alta Greene, Battle Creek
15. Annual Report of The Council: Robert J. Mason, M.D., Birmingham
16. Progress Report of MSMS Judicial Commission: Donald N. Sweeny, Jr., M.D., Detroit
17. Report of Delegates to the American Medical Association: Luther R. Leader, M.D., Royal Oak
18. Report of Michigan Medical Service: John M. Wellman, M.D., Lansing
19. Reports of Committees of the House of Delegates
20. Reports of MSMS Standing and Special Committees
21. Introduction of Resolutions

1:30 p.m.—REFERENCE COMMITTEE MEETINGS

8:00 p.m.—THIRD MEETING

22. Supplemental Report of Committee on Credentials
23. Unfinished Business
24. Introduction of Resolutions; Other New Business
25. Reports of Reference Committees

* * *

TUESDAY, SEPTEMBER 26

8:30 a.m.—FOURTH MEETING

26. Supplemental Report of Committee on Credentials
27. Unfinished Business
28. Reports and Supplemental Reports of Reference Committees

11:30 a.m. 29. PRESENTATIONS AND AWARDS
Certificates of Commendation
Michigan's Outstanding Physician
Fifty-Year Awards
Awards to MSMS Employees

NOON—Corporate Meeting, Michigan Medical Service — Grand Ballroom, Pantlind Hotel

AFTERNOON—REFERENCE COMMITTEES MEET

8:00 p.m.—FIFTH MEETING

30. Supplemental Report of Committee on Credentials
31. Unfinished Business
32. Supplemental Reports of Reference Committees
33. ELECTIONS
    Councilors
        1st District—Ralph R. Cooper, M.D., Detroit—Incumbent
        1st District—Don W. McLean, M.D., Detroit—Incumbent
        1st District—Robert K. Whiteley, M.D., Detroit—Incumbent
        4th District—Don Marshall, M.D., Kalamazoo—Incumbent
        5th District—John R. Pedden, M.D., Grand Rapids—Incumbent
        6th District—Harold H. Hiscock, M.D., Flint
        14th District—Harold F. Falls, M.D., Ann Arbor—Incumbent
    Delegates to the American Medical Association:
        Otto K. Engelke, M.D., Ann Arbor—Incumbent
        John R. Heidenreich, M.D., Daggett—Incumbent
        Luther R. Leader, M.D., Royal Oak—Incumbent
        Robert E. Rice, M.D., Greenville—Incumbent
    Alternate Delegates to the American Medical Association:
        Wyman C. C. Cole, Sr., M.D., Detroit—Incumbent
        Bradley M. Harris, M.D., Ypsilanti—Incumbent
        G. B. Saltonstall, M.D., Charlevoix—Incumbent
        Harold A. Furlong, M.D., Pontiac—Incumbent
    Election of President-Elect
    Election of the Speaker of the House of Delegates
    Election of the Vice-Speaker of the House of Delegates
34. Introduction of the new MSMS President-Elect—Bradley M. Harris, M.D., Ypsilanti, incoming President
35. Adjournment

MSMS Delegates and Alternates For 1967 MSMS House of Delegates

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Vice Speaker:
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William M. Moon, M.D., 828 Oak Street, Cadillac

* * *

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(Alternate not elected)

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John D. Snider, M.D., 1827 Argentina Dr., SE, Grand Rapids 49506

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(Continued on Page 1011)

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PSYCHIATRY AND NEUROLOGY
Robert B. Clarke, M.D., 76 W. Adams Ave., Detroit 48226
(Alternate not elected)

PUBLIC HEALTH AND PREVENTIVE MEDICINE
G. Frederick Moench, M.D., 147 Center St., Sanford 48657
Irwin C. Sweet, M.D. (deceased), Gladwin 48624

RADIOLOGY
Benjamin R. Van Zwalenburg, M.D., 2116 Coronado, SE, Grand Rapids 49506
Karl K. Latteier, M.D., 15025 West 8 Mile Rd., Detroit 48237

SURGERY
John W. Derr, M.D., 1145 David Whitney Bldg., Detroit 48226
(Alternate not elected)

UROLOGY
Murray S. Mahlin, M.D., 16820 Greenfield Ave., Detroit 48235
Edward J. Shumaker, M.D., 75 Lothrop, Detroit 48202

Health Council Reports 19 More MD Placements

Recent placements by the M.D. Placement Service of the Michigan Health Council included the following: Eugene P. O'Donnell, M.D. (Trenton); Orhan Baybura, M.D. (Edmore); Charles T. Vear, M.D. (Hillsdale); Kenneth Kleyn, M.D. (Cadillac); N. C. Sekharan, M.D. (Detroit - Detroit General Hospital); Mrs. N. C. Sekharan, M.D. (Detroit - Huxel Hospital); Nikolas Zografov, M.D. (Detroit - Holy Cross Hospital); Robert Lewis, M.D. (Sturgis); Richard Novak, M.D. (Frankfort); Henry Gall, M.D. (Livonia); H. B. Stibitz, M.D. (Alpena); Donald Sikkema, M.D. (Spring Lake - Grand Haven - Ferrysburg); C. A. Philippon, M.D. (Alma); David Amos, M.D. (Muskegon); Robert Gamble, M.D. (Grand Haven); Frederick Holland, M.D. (Midland); Robert Grunawalt, M.D. (Lapeer); Bernhardt Pederson, M.D. (Bay City); and Richard Morin, M.D. (Standish).

Extract of Council Minutes, June 14:

The Council heard a progress report from the Michigan Hospital Research Educational Reserve by Board Member Hira Branch, M.D., Flint.

At the request of A. E. Heustis, M.D., Director of the Michigan Department of Public Health, The Council authorized the designation of an appropriate MSMS committee to act in an official liaison capacity with a public health advisory council. Additional matters of interest regarding new services of the Bureau of Laboratories comments on the new Nurse Practice Act, nursing home licensure, study on ambulance safety, and fluoridation of community water supplies were discussed by The Council and by Director Heustis.

Michigan Medical Service reported on a new payment mechanism for physicians, revised benefit program for subscribers, negotiations with the motor industry, and operational experience with Medicare and Medicaid.

The Council authorized the appointment of a liaison committee with the Michigan State Podiatry Association.

With deep regret The Council accepted the resignation of MSMS Secretary Oliver B. McGillicuddy, M.D., Lansing.

MSMS representatives to the AMA Communications Institute were Brock Brush, M.D., and H. Clay Tellman, M.D., in addition to selected staff members.

MSMS Legal Counsel reported that a major portion of his time in recent weeks had been spent in preparing the MSMS *amicus curiae* brief filing with the Supreme Court of Michigan regarding the matter of staff privileges.

The Chairman of The Council and President of MSMS reported to The Council their recommendations for chairmen of committees.

In accordance with the by-laws, The Council Chairman appointed a Judicial Commission Nominating Committee of seven members of The Council.

The Council adopted a report of the Ad Hoc Committee re Policy on Screening Procedures and authorized that its guidelines be recommended by The Council to all component medical societies for their consideration. Copies of the guidelines with covering letters are being sent to component society leaders.

Meet Our Fine, Outstanding 1967 Annual Session Exhibitors

One of the colorful and educational aspects of the MSMS Annual Session in Grand Rapids this September will be the interesting array of scientific and technical exhibits.

MSMS leaders say, "Take time to inspect each one — not just a look-see — but a real indepth study. You will be surprised at the wealth of new information they will offer you."

This year, the registration desk, the exhibits, and scientific sessions will be conveniently located on the first floor of the Civic Auditorium.

"This will be good news to the physicians who can recall the necessity of having to walk up and down stairs in past years," the leaders declare.

Following is a list of the firms who will be presenting technical displays at the 1967 MSMS Annual Session.

"We hope you will make a special effort to visit each booth to personally express your appreciation for the contribution they are making to your meeting. The intermission periods between scientific sessions will provide you with an excellent opportunity to study the exhibition."

MSMS also wishes to express its gratitude to those who have generously made program grants to the Annual Session. These contributors are:

Michigan Cancer Coordinating Committee
Michigan Heart Association
The Upjohn Company
Warner-Chilcott Laboratories

Abbott Laboratories
American Health Credit Plan of Michigan, Inc.
American Surgical Trade Association — District VI
Ames Company, Inc.
Astra Pharmaceutical Products, Inc.
Audio Digest Foundation
Ayerst Laboratories
Barry Laboratories, Inc.
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Ciba Pharmaceutical Products, Inc.
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Commercial Equipment Company
Creative Systems, Inc.
Dow Chemical Company
Eaton Laboratories, Inc.
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Encyclopaedia Britannica
Fellows-Testagar
Ferndale Laboratories, Inc.
Flint Laboratories, Inc.
Geigy Pharmaceutical
Gerber Products Company
Hoechst Pharmaceuticals, Inc.
Key Pharmaceuticals
Lederle Laboratories
Len-Tag Company
Eli Lilly & Company
J. B. Lippincott Company
Loma Linda Food Company
P. Lorillard Company
Marion Laboratories, Inc.
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Mead Johnson Laboratories
Medco Products Company
Medical Protective Company
Merck Sharp & Dohme
Meyer Laboratories, Inc.
Michigan Association of Collection Agencies
Michigan Bell Telephone Company
Michigan Medical Service
North American Pharmacal
North States Aviation
Ortho Pharmaceutical Corporation
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Pet Milk Company
R. J. Reynolds Tobacco Company
A. H. Robins Company, Inc.
Roche Laboratories
Rollins Shoes, Inc.
Wm. H. Rorer, Inc.
Ross Laboratories
C. J. Rouser Supply Company
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Schering Corporation
G. D. Searle & Company
Seven-Up Bottling Company of Western Michigan
Sherman Laboratories
Siemens Medical of America, Inc.
Smith, Kline & French Laboratories
E. R. Squibb & Sons
Ben P. Stratton Agency, Inc.
The Stuart Company
Syntex Laboratories, Inc.
S. J. Tutag & Company
Union Bank & Trust Company
United States Tobacco Company
U. F. Vitamin & Pharmaceutical Corporation
Warren-Teed Products Company
Westwood Pharmaceuticals
Winthrop Laboratories, Inc.
W-T-S Pharmaceuticals
Wyeth Laboratories
Wynn Pharmaceuticals, Inc.

New Law Accepts National Board Exam in Michigan

Public Act 233 (Senate Bill 637) "To permit the State Board of Registration in Medicine to accept, in lieu of its own test, a certificate of passage of the examinations given by the National Board of Medical Examiners, as a prerequisite to licensing an MD in Michigan," was signed by Governor Romney on July 10, 1967, and given immediate effect.

This Bill was introduced by State Senator Harold J. Volkema in March at the request of MSMS and by the 1966 MSMS House of Delegates.

With the passage of this Act, only one other state remains that has not accepted the National Board Test. The National Board Test is constructed by leading national experts in their respective scientific fields and is recognized by all medical schools. Although this Act is permissive in that the Board need not accept the National Board Test unless the Board considers it equivalent to the tests now being given by the Michigan Board of Registration in Medicine, passage will aid immeasurably in attracting needed doctors into the State. Previously, non-acceptance of this nationally recognized examination created a roadblock to attracting doctors of medicine to Michigan.

The Act amends Section 3 of Act No. 237 of the Public Acts of 1899, entitled "An Act to provide for the examination, regulation, licensing and registration of physicians and surgeons, and for the punishment of offenders against this Act, and to repeal acts and part of acts in conflict therewith," as amended by Act No. 142, the Public Acts of 1959, being Section 338.53 of the compiled laws of 1948.

MSMS President C. Allen Payne, M.D., declares, "MSMS is extremely gratified at the enactment of this necessary and urgent legislation, congratulates the Legislature, and wishes to give a special salute to Senator Volkema for his perseverance and support of this legislation."

A salute is in order to those members of MSMS who devoted their time, effort and medical knowlelge in making their views known to their respective state legislators and also to Dean William Hubbard, M.D., President-Elect B. M. Harris, M.D., and others who testified in favor of the Bill.

Blood Transfusions Now a Service

(Editor's Note: Articles explaining new laws of interest to the medical profession will appear in future issues of Michigan Medicine. Here are the first two.)

Public Act 174, a bill to define blood banking and transfusion procedures as a service rather than a product, was passed by the recent legislature, signed by Governor Romney and given immediate effect.

This bill was introduced by Reps. Traxler, Holbrook, Baker and Woodman and immediately received MSMS support for enactment.

This Act is identical to a law recently passed in Mississippi which followed a Florida court decision rejecting the "sale concept" in that it should not apply where one is dealing with that which *cannot* be made *absolutely safe*. Heretofore, transference of whole blood was a personal service and immuned from regulation and control by those agencies authorized to regulate commerce. This has resulted in placing this area in a highly disturbing legal light.

At present, detection and removal of the virus which causes serum hepatitis, cannot be done with our current medical knowledge. Nonetheless, whole human blood is essential to human health and where its use is prescribed by a physician who is fully aware of the risk but, in his sound medical judgment, believes that the risk is justified, the presence of an unavoidable defect in the blood should not subject either the physician or the supplier to liability for breach of "Implied Warranty."

The entire Act with the new wording in italic now reads:

"Sec. 1. The procurement, processing, storage, distribution or use of whole blood, plasma, blood products, and blood derivatives, for the purpose of injecting or transfusing them, or any of them, into the human body for any purposes whatsoever *where there is no medical test to determine the fitness of such whole blood, plasma, blood products, or blood derivatives* is the rendering of a service and does not constitute a sale by any person participating therein, whether or not any remuneration is paid therefore.

The passage of this much needed legislation will greatly assist the patient in receiving the most current and technical medical assistance available and will also relieve the attending physician from possible legal impediments.

Norman D. Henderson, M.D., East Lansing, watches Governor Romney sign HB 2482 which was developed and supported by MSMS and introduced by Representative Charles J. Davis.

MSMS-Supported Bill To Ban Sub-Standard Fire Extinguishers

Fire extinguishers which can kill people as well as fires have been banned by a new Michigan law which was signed by Governor Romney this summer.

As passed by the legislature, House Bill 2482 adds private dwellings and vehicles to those places off limits for the sale and use of fire extinguishers whose chemicals reach a certain deadly level of toxicity.

"Some of these extinguishers give off gas as deadly as that used in World War I," according to Norman D. Henderson, MD, of East Lansing. "People often don't know how potentially dangerous those small aerosol fire extinguishers can be," Doctor Henderson continued.

Initiated by the Michigan State Medical Society at the suggestion of Doctor Henderson, the new law was introduced by Representative Charles J. Davis of Onondaga.

"Householders should check to see if they have safe fire extinguishers. The only way they can be sure is to have them checked at the fire station," concluded Doctor Henderson.

EXPLAINS WHY MSMS ANNUAL SESSION IS WORTH ATTENDING

Winslow G. Fox, M.D., Ann Arbor, declares: "Briefly there are four reasons why I regularly attend the MSMS Annual Session:

1. I enjoy hearing new ideas presented concisely and with enthusiasm, by someone who has a vital grasp of some aspect of medical practice that is useful to me. Reading is fine, but all too often the time for this is pre-empted by other things. Going to a medical meeting insures that the time will be devoted to the necessary post-graduate education.

2. The scientific exhibits provide a way for me to move, at my own speed among areas of particular interest to me. If I get too bored, or confused, I can quickly move on to a more fruitful exhibit.

3. The change of pace is pleasing. I find that I can return to patient care and the demands of the telephone, with greater enthusiasm when I've been away for a little break.

4. I enjoy meeting old friends — some of whom I've little chance of seeing except at such medical meetings. Also, my wife and I enjoy some relaxed evening meals together.

Claude E. Weston, M.D., Owosso, states:

The MSMS annual session always attracts me for several reasons:

(1) I see many old friends, and meet many new ones, whom I otherwise would probably not see for several years.

(2) The clinical papers and lectures are always refreshing and informative, and the exhibits always interesting.

(3) The meetings of the House of Delegates, of which I have been a member for twenty-four consecutive years, give a keen insight into the many aspects of economics and the political problems of medicine today.

I am planning to be in Grand Rapids in September.

Speaking of Malpractice Insurance ....

Have you checked the advantages of insuring with Shelby Mutual Insurance Company? This plan is sponsored by Michigan Association of the Professions and is available to members of the Michigan State Medical Society.

Here is why it might be beneficial for you to investigate

* Very Broad Coverage

* Competitive Premiums as Shown Below

Limits	Class 1	Class 2	Class 3	Class 4	Premises Minimum Premium
100/300,000	$97.00	$122.00	$234.00	$349.00	$27.00

(Premises Coverage Required with Professional Liability)

Class 1 — PHYSICIANS — No surgery.

Class 2 — PHYSICIANS — Minor surgery or assisting in major surgery on own patients.

Class 3 — SURGEONS — General practitioners who perform major surgery or assist in major surgery on other than own patients.

Class 4 — SURGEONS — Specialists.

Write for complete information as to coverage and premiums.

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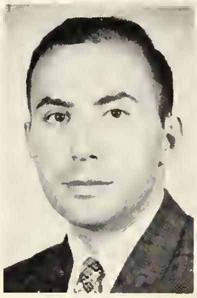
These Men, and Others, Will Speak at Annual Session

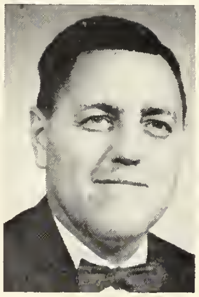
Keith H. Averill, M.D., Research Hospital and Medical Center, Kansas City, Missouri, will participate in the symposium on "Comprehensive Care in Coronary Artery Disease" on Wednesday, September 27, 8:45 to noon.



Henry N. Claman, M.D., University of Colorado Medical School, will participate in the seminar on "Primary Immunologic Deficiency Diseases" on Wednesday, September 27, 2:00 to 5:30 p.m.

John T. Dickinson, M.D., Pittsburgh, will conduct a round table discussion on "Facial Trauma" on Thursday, September 28, 2:00 to 3:15 p.m.

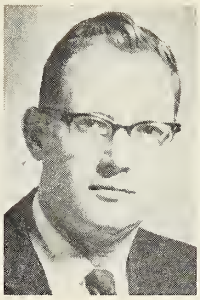
F. Robert Fekety, M.D., Johns Hopkins Hospital, Baltimore, will speak at the seminar on "The Use and Abuse of Common Therapeutive Agents" on Thursday, September 28, 10:45 to noon.



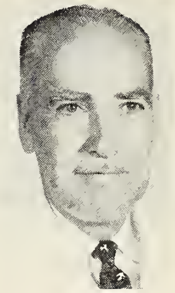
Bruce D. Graham, M.D., Children's Hospital, Columbus, Ohio, will speak at the seminar on "Emergencies in the Delivery Room" on Thursday, September 28, 8:45 to 10:00 a.m.

Richard M. Magraw, M.D., University of Minnesota Hospitals Comprehensive Clinic Program, will speak at the seminar on "The New Physician" on Wednesday, September 27, 2:00 to 3:15 p.m.

William H. Sewell, M.D., Guthrie Clinic, Sayre, Pennsylvania, will participate in the symposium on "Comprehensive Care in Coronary Artery Disease" on Wednesday, September 27, 8:45 to noon.



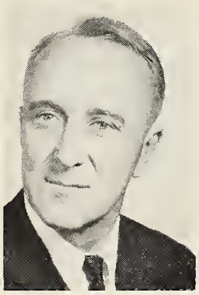
Benjamin H. Sullivan, M.D., Cleveland Clinic, will speak at the round table on "The Management of Portal Hypertension" on Friday, September 29, 8:45 to 10:00 a.m.



A. Earl Walker, M.D., Johns Hopkins Hospital, will participate in the seminar on "Surgical Emergencies" on Thursday, September 28, 3:00 to 5:30 p.m.

William R. Willard, M.D., University of Kentucky, will participate in the seminar on "The New Physician" on Wednesday, September 27, 2:00 to 3:15 p.m.

Frederick P. Zuspan, M.D., University of Chicago, will participate in the seminar on "Emergencies in the Delivery Room" on Thursday, September 28, 8:45 to 10:00 a.m. and will speak at the September 28 meeting of the Section of Obstetrics and Gynecology on "Thoughts about Toxemia of Pregnancy."



F. S. Hoffmeister, M.D., Roswell Park Memorial Institute, Buffalo, New York, will participate in the round table discussion on "Head and Neck Malignant Surgery" on Thursday, September 28, 2:00-3:15 p.m.

Robert E. Kinsinger, Ph.D., Division of Education and Public Affairs, W. K. Kellogg Foundation, will participate in the round table discussion on "Paramedical Personnel — Extra Hands for the Doctor" on Wednesday, September 27, 8:45-10:00 a.m.

The eight-story Basic Science Building of Wayne's School of Medicine will be located just west of the WSU Medical Research Building, shown at the right. Floor space will total just under half a million square feet. The teaching facility will house six of the medical school's 25 departments as well as administrative and service facilities.

WSU to Begin Work This Fall on Basic Science Building

With grants totalling $11,677,000 from the U.S. Department of Public Health plus funds from the State of Michigan, Wayne State University will begin construction this fall of a new eight-story basic science building.

The new teaching facility will permit, when funds are available, the school of medicine to almost double in size from 125 to 200 entering freshmen.

Completion is scheduled for 1970.

Besides housing administrative and service facilities, the building will be basic science headquarters for the first two years of medical school.

The $23.5 million dollar structure will have student study areas equipped with calculators, typewriters, and fixed microscopes. Closed circuit television will provide for televising from area hospitals. Besides research areas and two-story lecture halls, the building will contain 32 multi-discipline laboratories, each designed to serve as home base for 16 students. Instead of students moving from room to room, professors will do the moving to conduct classes.

The new basic science building will be located just west of the WSU Medical Research Building, which was completed in 1964, and directly across Brush Street from Grace and Harper hospitals.

In its plans for the Medical Center, which the basic science building will be part of, the University will construct a $2 million medical library, an outpatient clinic, a conference center, and quarters for research animals.

Total cost of the new medical campus which will cover 25 acres will be approximately $56 million for land and construction.

Alcohol and Driving Dangers Described

The danger of mixing alcoholic beverages and driving was emphasized at the University of Michigan Sesquicentennial Symposium on Highway Safety, sponsored by the Highway Safety Research Institute.

Nathaniel J. Ehrlich, a research psychologist working with Melvin L. Selzer, M.D., at the Institute, indicated that a questionnaire test, if given widespread use, could serve as an initial step in isolating delinquent traffic offenders who are alcoholics. It was pointed out by the researchers that those alcoholics who attempt to fake their problem on such a questionnaire can readily be identified and separated from the population at large. They cited an earlier study of fatal accidents in Washtenaw County which indicated that 36 of 96 drivers who were at fault were positively diagnosed as alcoholics. It was suggested that a study of delinquent state drivers be undertaken as an initial step in isolating alcoholic drivers and in the development of a law to rule them from the road.

Robert A. Moore, M.D., of the Swedish-American Hospital, Rockford, Illinois, pointed out that the accident driver is often impulsive, immature, and antisocial. He is intolerant to frustration and may have paranoid and suicidal feelings. Doctor Moore stressed that the kind of person who has an accident and the kind of person who becomes alcoholic are similar. An analysis of many studies of fatal accidents indicates that from 25 to 75 percent of drivers responsible for the accident have been drinking. In one study quoted 46 percent of such drivers had alcohol levels above the "usual legal level of intoxication." Further substantiation of these statistics is the fact that six times as many license revocations occur in alcoholics in the general population.

Doctor Moore, formerly of Ypsilanti, concluded that it is most unfortunate that in the face of these overwhelming statistics and the needless slaughter, it is difficult to enforce present laws or to initiate improved legislation to change the situation.

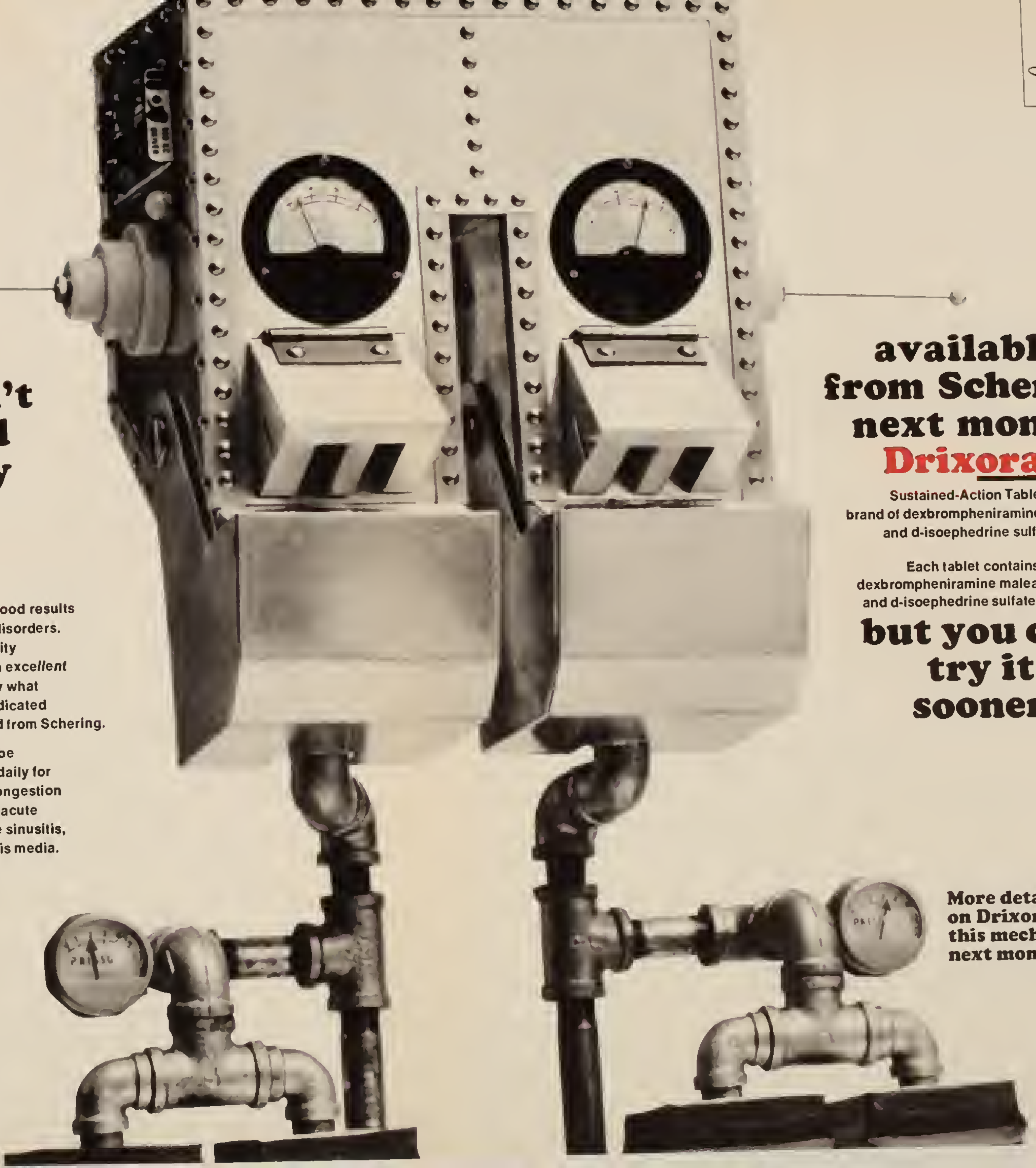
SINAI HONORS FOUR

Four physicians at Sinai Hospital, Detroit, were honored at recent alumni day activities of physicians and dentists who are graduates of Sinai's education program.

Howard K. Weindling, M.D., was selected as the hospital's top intern. Named resident of the year was Mark P. Owens, M.D., and A. S. Goldstein, M.D., was chosen attending physician of the year.

Emanual R. Casenas, M.D., was presented the Harry E. August Award as the outstanding resident in psychiatry.

Schering



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Most oral decongestants produce adequate or good results
in most patients with rhinitis and other U.R.I. disorders.
An oral decongestant's bid for superiority
must be justified by a demonstrated increase in *excellent*
results in *more* patients. And that is exactly what
double-blind and crossover studies have indicated
about a coming entry into the oral decongestant field from Schering.

Next month, you will be able to prescribe
DRIXORAL Sustained-Action Tablets twice daily for
24-hour relief of upper respiratory mucosal congestion
in seasonal and perennial nasal allergies, acute
rhinitis and rhinosinusitis, acute and subacute sinusitis,
eustachian tube blockage, and secretory otitis media.

available from Schering next month Drixoral™

Sustained-Action Tablets
brand of dexbrompheniramine maleate
and d-isoephedrine sulfate

Each tablet contains
dexbrompheniramine maleate 6 mg.,
and d-isoephedrine sulfate 120 mg.

but you can try it sooner

More details on Drixoral and this mechanical man next month.

[illegible]

Schering introduces Drixoral™

Double-blind and crossover studies[1-3] show superior results with an oral decongestant, but...

See last page of advertisement for clinical considerations.

see previous page for special pre-introductory sample offer for New Drixoral™

Sustained-Action Tablets
brand of dexbrompheniramine maleate
and d-isoephedrine sulfate

Each tablet contains dexbrompheniramine maleate 6 mg., and d-isoephedrine sulfate 120 mg.

Clinical considerations: Contraindications—DRIXORAL should not be given to children under 12 years of age. Until animal studies support the safety of this preparation for use during gestation, DRIXORAL should not be administered to pregnant women. *Precautions*—Although isoephedrine causes practically no pressor effect in normotensive individuals, it should be used with caution in patients with hypertension, coronary artery disease and hyperthyroidism. Dexbrompheniramine maleate may cause infrequent and usually mild drowsiness; should this occur, the patient should not engage in mechanical operations that require alertness. *Side effects*—Mild drowsiness has been observed in occasional patients receiving DRIXORAL. Although very infrequent complaints suggestive of sympathomimetic side effects have been noted, possible side effects of sympathomimetic origin include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesical sphincter spasm. For more complete details, consult package insert or Schering literature available from your Schering Representative or Medical Services Department, Union, New Jersey 07083.

References:
1. Pullen, F. W. 2nd, and Montgomery, W. W.: Arch. Otolaryng. 77:24, 1963.
2. Frank, D. I.: Curr. Therap. Res. 6:158, 1964.
3. Fierberg, A. A.: Ann. Allergy 22:324, 1964.

S-281

On Writers Program

Two University of Michigan faculty members are named on the program for the Annual Convention of the American Medical Writers Association to be held September 21-24 in Chicago.

They are: Richard Judge, M.D., Associate Professor of Medicine, who will be on the panel "Television in Medical Communication," and Ruth Good, M.A., Department of Physical Medicine and Rehabilitation, who will serve on the panel "Programs for Improving Medical Writing."

Describes Chemicals In Beetle Traps

The Michigan Department of Agriculture through John Dreves, of the Plant Industry Division, reports to physicians that the oil in the 20,000 yellow plastic, conical traps used against Japanese beetles is non-poisonous.

The Japanese beetle traps are placed on private property in metropolitan areas and contain an aromatic oil attractant. Mr. Dreves reports that the oil contains about one-half ounce of Eugenol and Anethole mixed.

Every year children reportedly ingest the bait, and families contact physicians and hospitals. The Michigan Department of Agriculture has notified the poison control centers in and near the communities where traps have been set and provided them with a sample of the attractant oil. Police also have been notified about the location of traps.

According to George H. Lowrey, M.D., Head of the University of Michigan Poison Control Center, there is no danger from the small quantity of the oil contained in the traps, and as the traps are placed at considerable distances apart, it is highly improbable that a child could possibly ingest more than ½ oz. of the oil attractant. Doctor Lowrey recommends that physicians and hospitals assure parents that the oil is not poisonous.

Plan Waste Disposal

Michigan is one of 32 states participating in a national campaign for planning safe and sanitary disposal of refuse and other solid wastes on a statewide basis.

Helping finance the new program is a $58,035 grant from the Solid Wastes Program of the Public Health Service's National Center for Urban and Industrial Health. The grant covers up to 50 percent of the cost of developing waste-disposal plans, and at the present the Program has awarded a total of $1,490,000 to the 32 participating states.

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We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

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Policy Explained For Pharmaceutical Services in Medicaid

Another one of the problems under the State Medical Assistance Program — Medicaid — has been the lack of specific information as to what allowable items of prescription services are permissible for Medicaid recipients. In order to clarify any misunderstanding of this part of the program, the Director of the Michigan Department of Social Services has recently approved a definitive policy relating to pharmaceutical services.

Below are listed those allowable services unanimously recommended by the Sub-committee on Pharmaceutical Services to the Medical Care Advisory Committee to the Director of the Department of Social Services:

ALLOWABLE SERVICES

The physician is permitted freedom of choice in prescribing the medication he deems necessary for the patient; this includes:

1. All prescription legend drugs and devices (e.g. diaphragm) requiring a prescription.
2. Insulin and other necessary drugs usually prescribed and needed for the medical management of the patient for a specifically diagnosed illness. These drugs must be obtained on written prescription which must be retained on file in the pharmacy for auditing purposes. Other medicine chest items (e.g. oral antiseptics, lozenges, dentifrices, simple laxatives, prophylactic vitamins, body lotions, personal hygiene items, common cold remedies, medicated rubs) are *not* included as allowable pharmaceutical services under this program.
3. The following medical accessories may be provided only on written order of the physician:
    - a. Hypodermic syringes
    - b. Hypodermic needles
    - c. Testape, Clinitest or similar diagnostic agents
    - d. Atomizer or Nebulizer
    - e. Colostomy bags and liners
    - f. Ileostomy bags and liners
    - g. Catheters
    - h. Dressings necessary for the medical management of the patient (incontinent pads, cellulose wadding, disposable diapers, surgical pads and tape). This does *not* include incidental first-aid supplies (e.g. adhesive bandages, sanitary napkins, etc.).

After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) .... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

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MEET THE LEADERS OF MICHIGAN HEALTH COUNCIL

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Michigan Health Hall of Fame

Every year since 1961 the Michigan Health Council has chosen a few select persons to the Health Hall of Fame in recognition of their outstanding contributions to the field of health and medicine. The recipients' names are enshrined on a plaque now located in the Health Careers Mobile as an inspiration to young persons considering a health career.

Those so honored in the past are:

1961

*L. Fernald Foster. M.D., Bay City and Detroit
*W. K. Kellogg, Battle Creek
Thomas Francis, Jr., M.D., Ann Arbor
William J. Norton, Detroit
*Frederick Coller, M.D., Ann Arbor

1962-1963

*Harry B. Zemmer, M.D., Lapeer
*Sebastian S. Kresge, Detroit
Henry F. Vaughan, D.P.H., Ann Arbor
*Frederick G. Novy, M.D., Ann Arbor

1964

Reuben Kahn, Sc.D., M.D. (Honorary), Ann Arbor
Miss Emilie Sargent, Detroit
Homer H. Stryker, M.D., Kalamazoo

1965

Emory W. Morris, D.D.S., Battle Creek
Charles S. Mott, Flint
E. Gifford Upjohn, M.D., Kalamazoo

1966

Albert C. Furstenberg, M.D., Ann Arbor
*John M. Sheldon, M.D., Ann Arbor
Wm. S. McNary, Detroit

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*Deceased

Many Michigan Physicians Speak, Show Exhibits at AMA Scientific Session

The spotlight was on 81 Michigan physicians during the AMA Scientific Session at Atlantic City. Others served as members of the Michigan delegation to the AMA.

Michigan doctors also spoke at scientific sessions. They presented technical exhibits. They served as leaders of AMA Sections. They participated in clinical demonstrations. They showed educational films that they had produced.

The following information is from the AMA Convention program booklet.

GENERAL MEETING SPEAKERS

Among those participating in the General Scientific Meetings were:

Herbert E. Pedersen, MD, and Joseph N. Schaefer, MD, both of Detroit, panel members for a discussion on "Backache."

SECTION LEADERS

The following Michigan men were prominent in AMA Sections:

Kenneth P. Mathews, MD, Ann Arbor, Delegate, AMA Section on Allergy, and also a member of the Committee of the Council on Scientific Assembly.

Paul R. Dumke, MD, Detroit, AMA Section on Anesthesiology representative to Scientific Exhibit, and a member of the Committee of the Council on Scientific Assembly.

Clarence S. Livingood, MD, Detroit, Delegate, AMA Section on Dermatology and a member of the Committee on the Council on Scientific Assembly.

E. Richard Harrell, Jr., MD, Ann Arbor, Assistant Secretary, AMA Section on Dermatology and a member of the Committee of the Council on Scientific Assembly.

H. Marvin Pollard, MD, Ann Arbor, Alternate Delegate, AMA Section on Gastroenterology.

Harold F. Falls, MD, Ann Arbor, Delegate, AMA Section on Ophthalmology and a member of the Committee of the Council on Scientific Assembly.

Edgar E. Martmer, MD, Harper Woods, Delegate, AMA Section on Pediatrics and a member of the Committee of the Council on Scientific Assembly.

George H. Koepke, MD, Ann Arbor, Assistant Secretary, AMA Section on Physicial Medicine, and a member of the Committee of the Council on Scientific Assembly.

Norman D. Nigro, MD, Detroit, Secretary, AMA Section on Proctology and a member of the Committee of the Council on Scientific Assembly.

Kenneth L. Krabbenhoft, MD, Detroit, Secretary, AMA Section on Radiology and a member of the Committee of the Council on Scientific Assembly.

SECTION SPEAKERS

These Michigan physicians participating in programs for the many AMA Sections, and specialty groups, according to the program were:

Guenter Corssen, MD, Ann Arbor, discussant, Section on Anesthesiology panel about "Effect of Nitrous Oxide on Middle-Ear Dynamics and Hearing."

Y. Mishima, MD, and H. K. B. Pinkus, MD, both of Detroit, presentation before Society for Investigative Dermatology about "Electron Microscopy of Stripped Human Epidermis."

J. Gumucio, MD, C. Feldkamp, MD, and I. A. Bernstein, MD, all of Ann Arbor, presentation before Society for Investigative Dermatology about "Studies on the Localization of the 'Histidine-Rich' Peptide Material Present in the Epidermis of the Newborn Rat."

Edmund D. Lowney, MD, George M. Kreye, MD, and E. Richard Harrell, Jr., MD, all of Ann Arbor, presentation before Section on Dermatology about "The Scalded Skin Syndrome in Small Children."

Richard A. Rasmussen, MD, Grand Rapids, participant in Fireside Conference for AMA Section on Diseases of the Chest on "Carcinoma of the Lung."

Robert F. Ziegler, MD, Detroit, moderator in Fireside Conference for AMA Section on Diseases of the chest on "Means of Detecting Right and Left Ventricular Hypertrophy."

Edwin L. Cohen, MD, Ann Arbor, participator in Fireside Conference for AMA Section on Diseases of the chest on "Treatment of Hypertension."

Philip Metcalfe Binns, MD, Detroit, presentation in Multidiscipline Research Forum for AMA Section on Experimental Medicine and therapeutics on "Spontaneous Recovery of Facial Move-

(Continued on Page 1028)

"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"

The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

ments after Excision of a Segment of the Facial Nerve."

Otto Gaco, MD, Richard L. White, MD, Ralph L. Brandt, MD, Joseph J. Bookstein, MD, and Joe D. Morris, MD, all of Detroit, presentation in Multidiscipline Research Forum for AMA Section on Experimental Medicine and Therapeutics on "Early and Chronic Assessment of Function of the Aortomyocardial Antogenous Vein Graft."

Gerald A. Lo Grippo, MD, Thomas A. Fox, MD, and Melvin A. Block, MD, all of Detroit, presentation in Multidiscipline Research Forum for AMA Section on Experimental Medicine and Therapeutics on "Immunoglobulin Determinations as an acid in the Differentiation of Intrahepatic Virus Infections from Extrahepatic Obstructive Jaundice."

Charles G. Child, III, MD, Ann Arbor, discussed "A Surgeon's Appraisal" during the "Symposium on Anesthesia, the Liver, Statistics and the Future," Section on Gastroenterology.

Ralph M. Burke, MD, Detroit, Moderator, Section on general practice panel about "Management of Rectal Problems during Pregnancy."

Bruce Proctor, MD, Royal Oak, report of representative to the American College of Surgeons Board of Governors during the business meeting of the AMA Section on Laryngology, Otology, and Rhinology.

H. Saul Sugar, MD, Detroit, presentation before Section on Ophthalmology about "Further Experience with Posterior Lamellar Resection of the Cornea for Epithelial Implantation Cyst."

Harold F. Falls, MD, Ann Arbor, presentation before Section on Phthalmology about "Leber's Congenital Amaurosis — Study of an American Family."

Alfred B. Swanson, MD, Grand Rapids, presentation before Section on Orthopedic Surgery about "An Exercise Program for the Cranio-Cervical Syndrome."

H. C. Bruckner, MD, S. B. Avery, MD, D. Stetson, and V. N. Dodson, MD, all of Ann Arbor, presentation before Section on Preventive Medicine about "Clinical and Immunologic Appraisal of Workers Exposed to Di-iso-cyanates."

Joseph L. Ponka, MD, Detroit, presented a movie on "Hernia" during a symposium on "Inguinal Hernia" and participated on the panel.

EXHIBITORS

Many MSMS members, often in conjunction with medical schools and hospitals, offered exhibits at the AMA Convention. The program listed the following:

The AMA and the Arthritis Foundation presented Demonstration Clinics on Arthritis. John W. Sigler, MD, Detroit, was a member of the four-man sponsoring committee. Robert Christopher, MD, Ann Arbor, participated in a demonstration clinic on "Physical Medicine in Arthritis."

Franklin V. Wade, MD, Flint, was a member of the four-man sponsoring committee for Special Exhibits on Fractures.

An exhibit about "Electomyography in Collagen Disease" was presented by Robert P. Christopher, MD, and Leonard F. Bender, MD, both of Ann Arbor.

An exhibit about "A New Method of Measuring Myocardial Blood Flow in Man" was presented by Richard J. Bing, MD, Charles Cowan, MD, Clarke Daniels, MD, Albert Cohen, MD, and Edward Zaleski, MD, all of Detroit.

An exhibit about "Therapy of Toxic Megacolon on Ulcerative Colitis" was presented by Richard L. Collier, MD, Jorge Gomez, MD, Bernard Schuman, MD, and Brock E. Brush, MD, all of Detroit.

An exhibit about "Saving the Diabetic Foot" was presented by W. L. Lowrie, MD, M. A. Block, MD, R. D. Hohl, MD, W. E. Redfern, MD, and F. W. Whitehouse, MD, all of Detroit.

An exhibit about "Brain Abscess and the Defective Heart" was presented by T. Connolly, MD, E. Heinze, MD, R. S. Knighton, MD, E. L. Quinn, MD, F. Cox, MD, and R. F. Ziegler, MD, all of Detroit.

An exhibit about "Head Injury — Mechanisms and Prevention" was presented by E. S. Gurdjian, MD, L. M. Thomas, MD, L. M. Patrick, and V. R. Hodgson, all of Detroit.

An exhibit about "Experimental Toxemia of Pregnancy" was presented by A. A. Hodari, MD, and C. Paul Hodgkinson, MD, both of Detroit.

An exhibit about "Biochemical Control of Bone Modeling Architecture" was presented by Harold M. Frost, MD, Detroit, and two Detroit dentists.

An exhibit about "The Immunofluorescent Tumor Imprint Technique to Detect Antinuclear Factors" was presented by Gerald Fine, MD, Detroit, and two associates.

An exhibit about "Malignant Melanomas:: Subcellular Differentiation of Neuocytic and Melano-

Best Exhibit!

The coveted Hektoen Gold Medal for the best exhibit of original investigation at the AMA Convention was given to C. Paul Hodgkinson, M.D., and A. Alberto Hodari, M.D., both of Detroit.

The two physicians, with the Henry Ford Hospital, were cited for the originality and excellence of their presentation about "Experimental Toxemia of Pregnancy."

cytic Ontogeny" was presented by Yutaka Mishima, MD, Dearborn.

An exhibit about "The Highway Epidemics — No. 1 Killer of American Youth" was presented by five Physicians for Automotive Safety including Paul Gikas, MD, and also Donald Huelke, PhD, both of Ann Arbor.

An exhibit about "Medicare and Changing Hospitalization Patterns" was presented by Vergil N. Slee, MD, Ann Arbor, and an associate.

OTHERS IN SPOTLIGHT

The AMA Convention provided "Screening Examination for Physicians" again. Robert H. Berman, MD, Detroit, was listed among the Fellows of the American College of Cardiology who were available for consultation.

The AMA Motion Picture Program in the Convention Hall included:

"Goodbye to Captain Hook" by Leonard F. Bender, MD, and Gerald A. O'Connor, MD, both of Ann Arbor.

"Pediatric Basics — Apgar on Apgar" by F. J. Margolis, MD, Kalamazoo, and Virginia Apgar, MD, New York.

MSMS Committee Plans Drug Dependency Exhibit At 1967 Annual Session

An exhibit designed to update physicians' knowledge about the treatment, care, and rehabilitation of drug-dependent persons will be featured at the MSMS Annual Session.

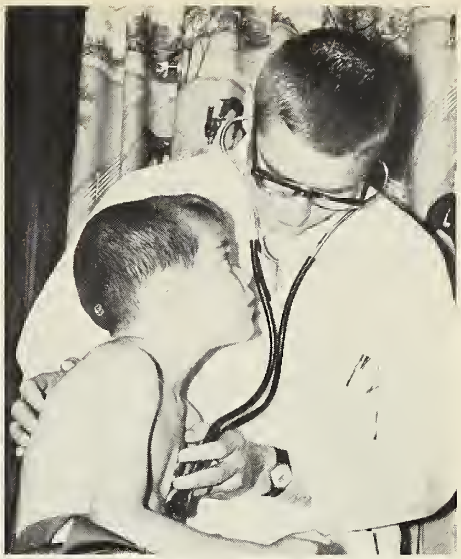
Initiated by the MSMS Committee of Alcoholism and Drug Addiction, the exhibit is being developed by H. A. Raskin, M.D., Detroit.

Assisting Doctor Raskin with the project are John Cook of the Public Health Education Division of the Michigan Department of Public Health and J. T. McConnell, also of the Michigan Department of Public Health.

Oliver, New Chairman, Pediatrics at U-M

William J. Oliver, M.D., has been appointed chairman of the University of Michigan Medical School's Department of Pediatrics and Communicable Diseases following the retirement of James L. Wilson, M.D.

Doctor Oliver, who has served as director of the pediatric laboratories at the University since 1959, was the unanimous choice of the faculty committee to recommend Doctor Wilson's successor. Through his efforts, the nation's first kidney donor bank was established at the University Medical Center last fall.



Richard J. Bower, M.D., a general practitioner at Portage examines one of his young patients.

Portage GP Remembers Loan From Ingham Society

An Ingham County Medical Society loan helps make possible the work of Richard J. Bower, M.D., in Portage, near Kalamazoo. While a third-year student at University of Michigan, he received a $1,000 loan from Ingham County.

In a letter to Ingham County Medical Society, Doctor Bower wrote, "Your financial assistance helped me obtain my goal, and I shall always be indebted to the doctors of your Ingham County Medical Society for this."

"I am impressed with the self-sacrifice made by your members to help a medical student, whom they did not even know, complete his studies. I am looking forward to the day when I will be in a position to give in a similar fashion."

"Lansing is my home town but even a medical student doesn't really get to know many doctors except his family physician," Doctor Bower continued. "Through the loan I got closer to the Ingham County doctors."

Doctor Bower observes that the young physician benefits from a county society loan and the county society can benefit also. "Of course there is no obligation to practice medicine in the county which gave you the loan" he said.

"The loan was helpful to me both financially and as a way of getting to know the Ingham county doctors better," Doctor Bower now a general practice physician, said.

Doctor Bower was graduated in 1964 and interned at Borgess Hospital in Kalamazoo. He has repaid the loan.

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GOING TO ANNUAL SESSION . . .

Aug. 25 — The Council, MSMS Headquarters, East Lansing

Sept. 14-16 — Central Association of Obstetricians and Gynecologists, Detroit

Sept. 14-16 — Annual Meeting of the American Thyroid Association, University of Michigan Medical School, Ann Arbor

Sept. 24-26 — MSMS House of Delegates, Black and Silver Room, Civic Auditorium, Grand Rapids

Sept. 26-28 — MSMS Woman's Auxiliary, Pantlind Hotel, Grand Rapids

Sept. 27 — MSMS Dinner Dance, Pantlind Hotel, Grand Rapids

Sept. 27-28 — Diet Therapy Conference, Pantlind Hotel, Grand Rapids

Sept. 27-28 — Michigan State Medical Assistants Society Convention, Morton House, Grand Rapids

Sept. 27-29 — MSMS Annual Scientific Session, Civic Auditorium, Grand Rapids

Sept. 29-Oct. 1 — American Academy of Child Psychiatry, University of Michigan Medical School, Ann Arbor

Oct. 5-7 — Medical School Alumni Reunion, University of Michigan Medical School, Ann Arbor

Oct. 9-13 — International Conference on Leukemia and Lymphoma, University of Michigan Medical School, Ann Arbor

Oct. 15-21 — National Community Health Week

Oct. 27-28 — Regional Meeting, American College of Physicians, University of Michigan Medical School, Ann Arbor

Nov. 2 — Southwestern Michigan Clinic Day

Nov. 8 — The Council, MSMS Headquarters, East Lansing

Nov. 15-17 — International Conference on Fertility and Family Planning — A World View, University of Michigan Medical School, Ann Arbor

Nov. 26-29 — AMA Clinical Convention, Houston

Nov. 26-29 — Conference on Genetics in Medicine, sponsored by the American College of Physicians, University of Michigan Medical School, Ann Arbor

Dec. 13 — The Council, MSMS Headquarters, East Lansing

March 26-27 — Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 23-28 — Student American Medical Association, Detroit

Tandearil®
oxyphenbutazone

Tandearil in Painful Shoulder

Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg. 6562-VI(B)R

For complete details, please refer to full prescribing information.

Geigy
Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil®
oxyphenbutazone

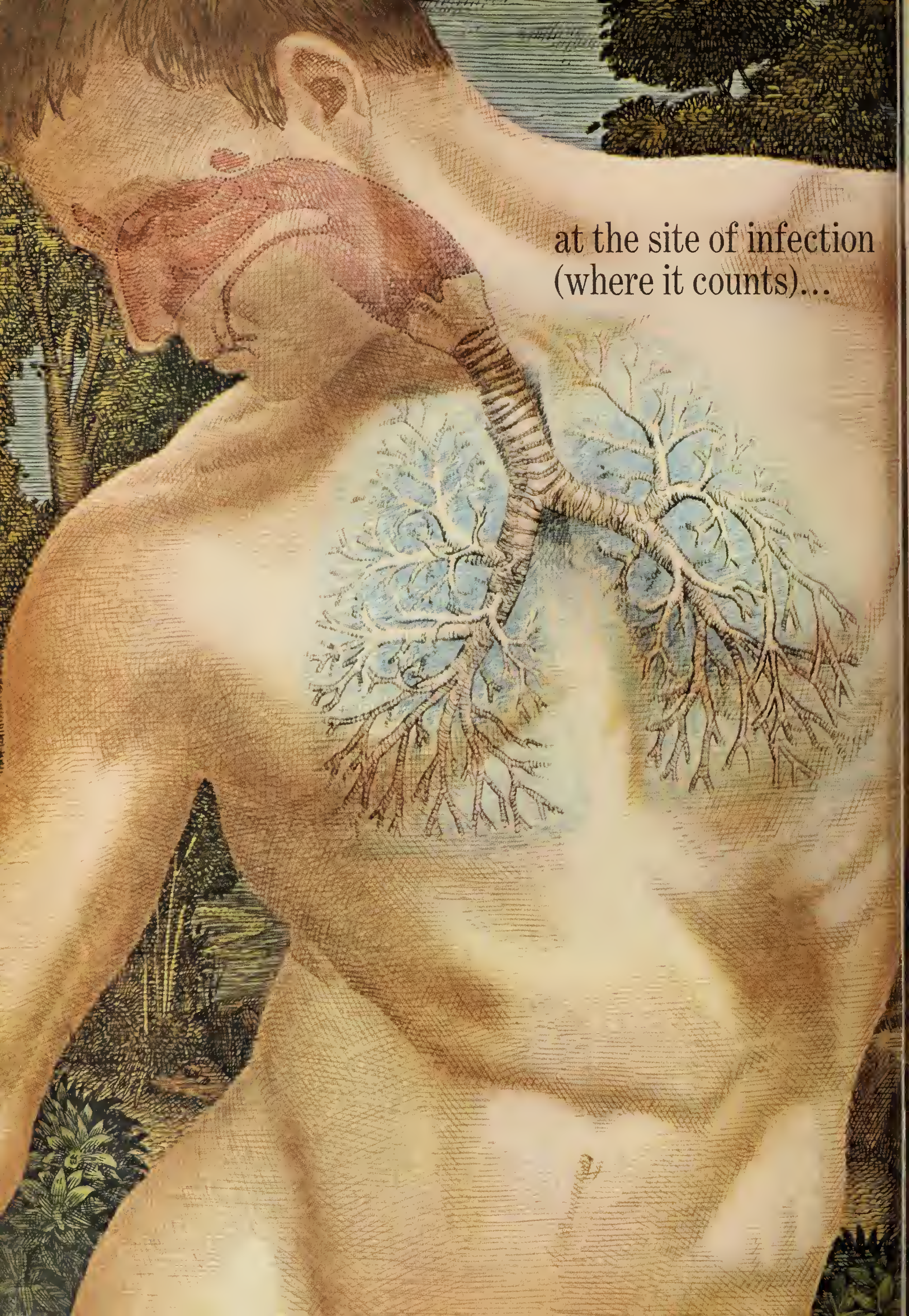
helps painful shoulders move again

3 out of 4 painful shoulder patients responded well

Sperling, I.L.: Applied Therap. 6 117, 1964	84.2% of 127 patients
Rosenbaum, E.E., and Schwarz, G.R. Northwest Med. 61:927, 1962.	81% of 48 patients

Please see adjoining page for brief prescribing summary.

TA-5094PC


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed . . . Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appear be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, elev alkaline phosphatase levels, negative or weakly positive cepl flocculation and thymol turbidity tests, elevated serum glut oxalacetic transaminase levels, peripheral eosinophilia, and mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has been reported in other patients taking prolonged courses o medication. Patients with chronic infection have been given to 2 Gm. of the drug daily for periods of two to six months, patients with rheumatic fever have taken prophylactic dos 0.5 Gm. daily for two years without difficulty. In one grou 144 patients who received the drug daily for two years, no j dice was noted. It was of interest that members of six of t patients' families, who were not taking the drug, had epis of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children who 250 mg. of Ilosone daily for an average of sixteen month rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who received icillin. There were no cases of jaundice in either group. Eleva of SGPT and serum alkaline phosphatase levels during the co of treatment was observed in one patient treated with Ilo and in two patients treated with penicillin. Seven other pati in the group receiving Ilosone and four others in the penic group showed elevations in one of the tests at some time du administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus i tions. Results of liver function tests in these patients comparable to those in a similar control group who had rece penicillin.

Gastro-intestinal disturbances not associated with hepati fects are observed in a small proportion of individuals as a r of a local stimulating effect of the medication on the alimen tract; however, the normal intestinal gram-negative bact flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the of erythromycin, there have been occasional reports of urtic skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of weight, the usual dosage is 5 mg. per pound every six hours children twenty-five to fifty pounds, 125 mg. every six h (Tablets Ilosone Chewable should be chewed or crushed swallowed with water.)

For adults and for children over fifty pounds, the usual do of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythrom therapy should be considered.

In the treatment of syphilis, the recommended total dosa 20 to 30 Gm. given in divided doses for a period of ten to fif days. Close follow-up of the patient is necessary since eryt mycin drugs have not had adequate evaluation in all stage syphilis. Examinations of spinal fluid are recommended as of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days recommended. In the treatment of gonorrhea, patients wi suspected lesion of syphilis should have a dark-field examina before receiving antibiotics, and monthly serologic tests sh be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equiva to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packa

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiva to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packa

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.- packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to ba in bottles of 50. [032

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

irst Chairman of Aero Medical Association, etroit Physician Honored by Federal Agency

An award for forty years of service to aviation edicine in Washington recently to Edgar E. Poos, M.D., Detroit, spotlights a creative career in aviation medicine which began with service to British flyers in World War I.

The Federal Aviation Agency gave the award to seven United States doctors at the International convention of the Aero Space Medical Association, atended by delegates from 24 countries. The seven ere the surviving members of a group of twelve octors who were first to receive appointments om the Department of Commerce to examine ivilian flyers in 1927.

One of the founders and first chairman of the ero Medical Association which had its initial eeting in Detroit in 1929, Doctor Poos has seen e group grow from one which made 4,000 pilot xaminations a year at its inception, to one which ow makes 400,000 yearly examinations.

"Medical aviation is a very exciting field of ork," Doctor Poos says. "My own interest in it ans the time when I helped give the returning harles Lindbergh his physical in 1927 to the me recently when I was called upon to advise t aircraft mechanics who were developing ear efects because of the noise of the huge engines. here's a lot of aviation history between Lindergh and the huge jets of today."

Another area of aviation medicine to which Docr Poos contributed was in solving the problem f pilots who passed out during a dive. He adised that a device he designed to hold in the ilot's abdomen and sometimes his legs to prevent lood from flowing out of his head into the abomen.

Commenting on modern aviation, Doctor Poos bserved that today's high rate of speed tends to crease tension in pilots.

He also remarked that "one of the big problems to get them to keep their weight down because f high blood pressure and heart trouble."

Doctor Poos continues to practice his specialties ophthamology and otolaryngology, as well as viation medicine, in his office at the Fisher uilding in Detroit. Though no longer practicing rgery, he is a graduate flight surgeon.

He is one of the few doctors who has a fellowip in both the Aero Space Medical Association nd the Civilian Aviation Medical Association.

AIRWAY
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Engineering Expert Rates Hospitals as Not Too Efficient

Hospitals are relatively inefficient institutions compared to industrial operations of equal size. This is the opinion of Richard C. Jelinek, Director of Systems Engineering at the University of Michigan's Bureau of Hospital Administration. A gap between research and application results from hospitals' unwillingness to seek out the information and researchers' frequent failure to provide a transitional approach and an understanding of personnel problems, he said.

Professor Jelinek emphasized that health service research must be viewed from top to bottom, starting with the national health problem, going through regional facilities and community problems, and settling on the hospital and other institutions.

Most of the extensive research in this area has been done in the last eight years. According to Professor Jelinek, research findings with a great potential for application are available in such areas as prediction of work load and the development of methodology for determining facility and personnel needs at community as well as at hospital levels.

AMA LISTS RESIDENCY REVIEW IN DETROIT

The Residency Review Committee for Psychiatry and Neurology of the American Medical Association will meet in Detroit this fall. The meeting will be held at the Pontchartrain Hotel on October 4.

"Arts for Everyone, Everyday" Is Aim Of State Council

The many physicians and wives who are active in local fine arts groups and projects will be interested in the First Annual Report of the new Michigan State Council for the Arts.

The Council seeks to "serve the needs of an increasingly culture conscious citizenry" explains Chairman Karl Haas, Detroit, in the Report.

Mr. Haas points with pride to many of the first-year activities that the Council, established June 2, 1966, by the Michigan Legislature, moved from "planning to doing."

The idea of the Council is to stimulate the study and presentation of performing and visual arts. How? By formulating "a significant program within each discipline of sufficiently varied interest t serve the current cultural interests of our citizens; by establishing "programs which will lend visibilit to the work of the Council" and which "will in n way compromise excellence in standards and ye remain within the limits of the budget at ou disposal."

During the first year of activities, Council-spon sored programs have emerged primarily from th initiative of the committees. Future programs wil hopefully come from interested groups and ind viduals throughout the state.

So far, only one major policy statement wit regard to fund allotment has been made: "Be cause of budgetary limitations, requests for capita outlay funds (for restoration, renovation, or ne construction) are discouraged."

The first general meeting of the Council for th Arts was held in Grand Rapids on October 1 and 16, 1966. During this time plans were mad for allocation of $100,000 and recommendation for 34 priority projects were submitted by eigh of the nine performing and visual arts committee

The nine committees are: Music, Literatur Communications Arts, Environmental Arts, Visua Arts, Museums, Theatre, Community Arts Coun cils, and Dance.

In the future the Council hopes to expand it budget for 1967-1968, and form a citizens' organ ization with state-wide representatives to raise pri vate funds.

This is done so that, in the words of Executiv Director E. Ray Scott, "We will arrive at the da in the not too distant future, when we can asser that in Michigan the arts are for everyone, ever day — not a sometime experience for the exclusiv enjoyment of a privileged few."

Mr. Scott formerly was associated with MSM before being appointed to organize and direct th Arts Council.

Photo above: Michigan Artist Clifford West.

Photo at right: Scene from Shakespeare's "Twelfth Night" produced by the University of Michigan for Michigan State Council for the Arts.

MSMS Council Adopts Guidelines For Health Screening Procedures

The MSMS Council has adopted the following guidelines for Health Screening Procedures and recommends them to component medical societies for their consideration:

In these guidelines, the word screening is used as: "The presumptive identification of unrecognized abnormalities by the application of tests, examination or other procedure."

"The Michigan State Medical Society endorses and supports health screening programs as a potentially useful medical tool in the field of preventive medicine and early diagnosis. The Society believes these programs, as an investigative procedure for both the public and the profession and as a means for early detection of disease, may be used beneficially for the improvement of health.

"It must be recognized, however, that screening programs, as an adjunct in diagnosis of disease, are part of the practice of medicine and that active physician participation is mandatory. There must be adequate safequards to protect the patient and the medical profession from unethical or illegal practices.

"In order that these programs may "serve humanity" and at costs commensurate with the services rendered, it is recommended:

"1. That the objective of such programs be:

To detect abnormalities at an early stage so that definitive diagnosis and effective treatment can be initiated.

To educate the public to the value of preventive medicine and to the advantage of having a personal physician.

To collect and evaluate data pertinent to the changing trends of disease.

"2. That the rights and responsibilities of the participants in these programs be clearly defined:

The sponsoring agency or agencies should plan, organize, and finance the program; publicize it to the public; maintain adequate records of the individual screenee and of the total results. In programs sponsored by multiple agencies prior coordination and agreement as to responsibility and reporting procedures are essential.

The sponsoring agency or agencies should seek and obtain medical guidance at the initiation of the program and follow medical direction until its completion.

The physician, or physicians, is responsible, legally and ethically, for all the medical practices. It is his privilege and responsibility to submit the plans at an early date to his county medical society and to obtain its approval before initiating the program.

The physician should be responsible for overall supervision of the tests, the medical records, evaluation of the program, and for reports of tests which must be submitted to the screenee's personal physician of its findings. If in the opinion of the physician in charge of screening the screenee is to be advised of the results, this information shall be limited to a statement as to whether the tests were normal or abnormal. No diagnosis or implication of diagnosis shall be given to the screenee.

The screenee must participate on a voluntary basis and his consent must be obtained for release of his records. It shall be his responsibility to seek treatment when indicated.

The Medical Society on request shall review and advise relative to the medical aspects of any proposed program and approve those that meet its criteria. It shall encourage the membership to participate in those programs it has endorsed. It shall receive reports of the results of these programs and disseminate pertinent data to the membership.

"3. That the sponsoring agency make available a public accounting of costs; and make no charge to the screenee.

"4. That physicians may contribute their services as members of advisory committees of the health agencies or of their Medical Society. However, they should be reimbursed for professional participation in screening programs.

"5. That the tests be safe, simple to perform, inexpensive and subject to accurate interpretation.

"6. That multiphasic screening should be used when feasible."

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Offer Tape Recordings Of Talks on Change

Tape recordings of speeches presented at the recent MSMS Conference on "The Challenge of Creative Change" are now available for county society meetings, workshops, and other conferences. Sponsored by MSMS, the conference was held for presidents, secretaries, and executive secretaries of component medical societies, delegates and alternate delegates to the MSMS House of Delegates, and members of The Council.

All tapes are 30 minutes long or less. Those available are:

1. "The Challenge," Robert J. Mason, M.D., Chairman, The Council; "Michigan Medical Schools' Plans for Increasing Medical Manpower," Bradley M. Harris, M.D., President-Elect; Ernest D. Gardner, M.D., Dean, WSU School of Medicine; Andrew D. Hunt, M.D., Dean, MSU College of Human Medicine.
2. "Medicare and Medicaid, Part I," Bernard P. Harrison, J.D., Director, AMA Legislative Department; R. Bernard Houston, Director, Department of Social Services, State of Michigan.
3. "Medicare and Medicaid, Part II," Paul T. Lahti, M.D., Chairman, MSMS Committee on Governmental Medical Care Programs, William E. Stevenson, Vice President. Claims Division, Michigan Blue Shield.
4. Introduction. C. Allen Payne, M.D., MSMS President; "Future Blue Shield/Blue Cross Contracts," Bennett J. McCarthy, Vice President and General Manager, Michigan Blue Cross; John C. McCabe, President, Michigan Blue Shield.
5. "Responsibilities and Methods of Utilization Review," Beverly C. Payne, M.D., Chairman, MSMS Committee on Evaluation, of Prepaid Medical Services; "Professional Liability Insurance," John C. Frakes, Jr., LL.B., Matheny, Schureman and Frakes Attorneys.
6. "Regional Medical Programs (Heart, Cancer, Stroke)," Don Marshall, M.D., MSMS Representative to and Vice President, Michigan Association for Regional Medical Programs, Inc., "Michigan Health Facilities Planning," D. Bonta Hiscoe, M.D., MSMS Representative to Michigan Health Facilities Planning Council.

The tapes may be obtained by writing MSMS, 120 West Saginaw, E. Lansing 48823.

Did You Know That?

Did you know that the AMA-ERF has in excess of $35,000,000 out in loans to approximately 19,000 students, interns and residents.

Did you know that Jerry Leu, M.D., recently became the 300,000th physician in the United States to obtain a loan from the AMA-ERF Loan Fund.

Fralick Retires, Ends 40 Years With U-M

F. Bruce Fralick, M.D., Ann Arbor, associated with the University of Michigan Medical School for 40 years, has retired as professor and chairman of the Department of Ophthalmology.

Commenting on Doctor Fralick's retirement, Medical School Dean William N. Hubbard, Jr., M.D., declared, "He has built a record of outstanding achievements, and as administrator, teacher, dedicated physician, and world-renowned ophthalmic surgeon and has brought great distinction to the University of Michigan."

Doctor Fralick completed his undergraduate work at the University of Michigan and received his M.D. degree from the Medical School in 1927. He then joined the University Hospital staff as an intern, and except for one year at the University of Chicago Medical School, he has remained at the U-M. He has served as professor and chairman of the Department of Ophthalmology since 1936.

MHC Gets New Grant For Smoking-Health Work

The Michigan Health Council has received an additional $22,788 grant from the National Clearinghouse on Smoking and Health of the United States Public Health Service to continue to coordinate the program and activities of the Michigan Council on Smoking and Health. During its first year, the Council co-sponsored the Michigan Institute for Smoking and Health at Michigan State University, stimulated the development of local and regional smoking councils throughout Michigan, and recommended to members of the Michigan State Legislature eight bills aimed at strengthening health education programs in Michigan schools so that children will be informed fully and accurately on the health hazards of cigarette smoking, alcohol and drug addiction, and other health problems.

Benjamin Yep is the coordinator of the smoking council. MSMS is a member organization.

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"Michigan Medicine" invites letters of 300 words or less for publication. Unsigned letters will not be considered; but signed letters will be printed anonymously if the author so requests.

Send letters to Publication Committee, MSMS, 120 West Saginaw, East Lansing, Michigan 48823.

We would like to take this opportunity to provide up-to-date information on the programs of the American Medical Association Education and Research Foundation for the doctors of Michigan.

During 1966, physicians individually and through their organizations contributed $954,164 to the Foundation. This is represented in gifts from 35,198 physicians and 170 physician organizations. The auxilliary activities produced $361,409. Additions to the program include Loan Guarantee Program $366,329, Institute $280,223, Unrestricted Funds $136,707 and Medical Schools $1,029,548.

As of this date, more than 19,000 medical students, residents and interns are participating in the Student Loan Program with approximately $39.5 million on loan.

Yours truly,
Richard M. Nelson
Director, Program Development
American Medical Association

The Michigan State Medical Society is certainly to be congratulated on the great growth in interest and attendance at the 1967 Conference on Medical Aspects of High School Sports.

I think you will find this kind of activity largely a self-generating and most satisfying experience. Sports are now a definite part of the American culture and physicians as well as people generally are tremendously interested.

Sincerely,
Fred V. Hein, Ph.D.
Secretary, AMA Committee on the
Medical Aspects of Sports

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book reviews

IOTIONALLY HANDICAPPED CHILDREN AND THE ELEMENTARY SCHOOL. By Elizabeth Rubin, Clyde B. Simson, M.D., Betwee. 286 pp. $12.50. Wayne State University Press, 1966.

A pearl of wisdom dropped in passing by Doctor ubin in this remarkable book is that the policy segregating the disturbed child from the regu- r classroom to "protect" his more nearly norm- classmates rests on a fallacy. For each trouble- aker that the teacher identifies, there are other iildren who also show seriously disruptive be- avior — a fact apparent to an astute clinical ob- rver, but not to the harassed teacher.

Special education programs, nevertheless, have long and respected tradition.

In this excellent monograph the authors, well own for their many years of professional dedi- ition to the treatment of emotionally handi- ipped children, set out to investigate the real npact of such a program.

Eighty-three children from kindergarten to sec- nd grade, who showed evidences of poor school adjustment, were divided into an experimental and a control group.

The first group received intensive attention from the teacher and psychotherapeutic management, mostly through consultation with a mental health expert. The second, or control group, remained in a regular classroom with no special help.

The findings of the experiment were somewhat unexpected. Children in the special program did indeed show improvement in the classroom, but this change did not carry over into their outside behavior. Some of the "control" children also made significant gains.

Using a new approach to the problem, the authors made a detailed, painstaking, and ingenious analysis of the manifested behavior of all the children involved. A cluster of related variables then appears which illuminates much of the disturbed youngsters symptomatology and makes by far the most interesting part of the book. Children with differing symptoms need different, specific educational approaches; their parents could benefit from skilled professional help.

Physicians and other people involved in the planning of children's programs under the community mental health legislation (Act 54 in Michigan), will profit from a careful study of this book.

Additional pruning and editing would have made the book more readable for the audience the authors had in mind, but it is no doubt a solid contribution to the growing literature in the area of child psychiatry and elementary education.

Jose' J. Llinas, M.D.
Assistant Professor of Medicine
(Psychiatry)
College of Human Medicine
Michigan State University

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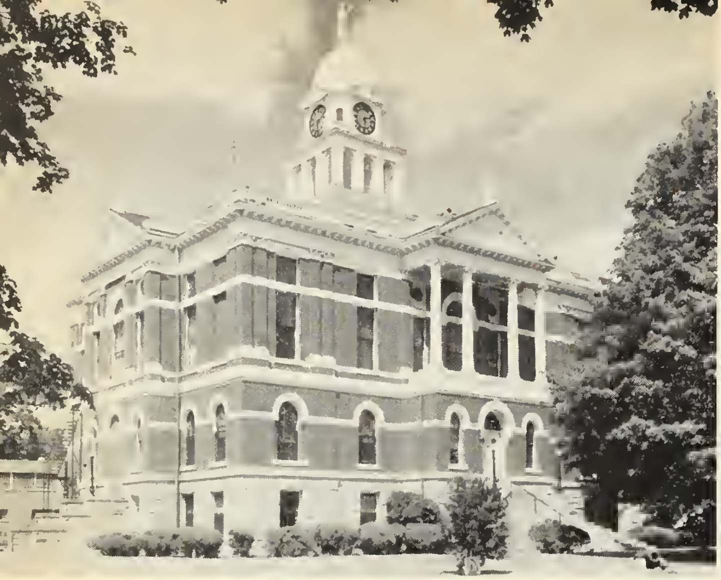

Where is this Michigan landmark?

Many physicians are interested in Michigan history and roll up many miles every year going to the many medical meetings.

Where is this building?

The photo was taken by Allen Stross, Detroit photographer, for the National Parks Service.

Have you seen this building?

The photo is part of a Mid-Michigan series of historic buildings, photographed by Mr. Stross for the Historic American Buildings Survey.

Where is this county courthouse?

In addition to the photographic studies of the old buildings, other information was recorded by a team of architects led by H. J. McKee of Syracuse University.

Where is the building?

If you answered "at Charlotte," you are correct. The handsome, impressive Eaton County Building is maintained in good condition and repair.

Seek Patients For Special Study

The National Cancer Institute requests physicians' cooperation for a continuing clinical study of Waldenstrom's macroglobulinemia and related hyperviscosity syndromes. The study is being conducted at the Clinical Center, National Institutes of Health, Bethesda.

The Center is interested in patients with retinopathy, mucous membrane bleeding, vertigo, or other clinical disorders associated with elevated serum viscosity.

Physicians interested in having their patients considered for this study may phone John R. Wunderlich, M.D., or Dean L. Mann, M.D., or John L. Fahey, M.D., Clinical Center, Room 4B-18, National Institutes of Health, Bethesda, Maryland 20014, phone 301/656-4000, ex. 65461.

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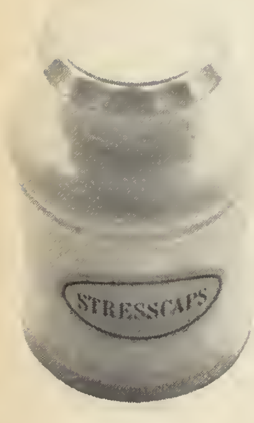

in memoriam

M. Burling, M.D., Grand Rapids

Wesley M. Burling, M.D., longtime Grand pids general practitioner, died June 26. He s 82.

Born in Muskegon, Doctor Burling received his dical degree from the University of Illinois dical School in 1916. He served his internship the City Hospital at St. Louis and was a resi-nt intern at Highland Park General Hospital, troit.

During World War I Doctor Burling served as First Lieutenant in the United States Army.

Affiliated with Butterworth Hospital for 30 rs, Doctor Burling was an honorary member the staff though he retired in 1952.

A Life Member of the Michigan State Medical ciety, his medical fraternity was Alpha Omega pha.

B. Fleischmann, M.D., Muskegon

Charles B. Fleischmann, M.D., Muskegon, family ysician for more than 50 years, died May 15 the age of 78.

A native of Muskegon, Doctor Fleischmann was graduate of Marquette University School of edicine, which in recent years paid him special bute for his long service to medicine.

After completing an internship in Minneapolis, octor Fleischmann practiced in Montana until orld War I, when he served in the Vannes Base ospital in France for the American Expeditionary rces.

Doctor Fleischmann did postgraduate work at e University of Chicago and at Harper Hospital, etroit.

He was a Life Member of the Michigan State edical Society, and was awarded a MSMS 50-ar Pin in 1962.

L. Garrett, M.D., Niles

Evan L. Garrett, M.D., 63-year-old Niles surgeon, ed May 27.

A graduate of Loma Linda University School of edicine, Doctor Garrett interned at St. Mary's ospital, Detroit. He practiced in Grand Rapids r 21 years and was twice chief of staff at wating Hospital, Niles.

He was a past president also of the Calloway ounty Medical Society in Kentucky. Professional emberships included: the International College Surgeons, the American College of Surgeons, the American College of Abdominal Surgeons, and the International College of Proctology.

Doctor Garrett was a former president of the Lions Club, a member of the Board of the Berrien County Red Cross, a past trustee of Andrews University, a member of the Chamber of Commerce, and the United States Power Squadron.

During World War II he served in the United States Army as a major. He was awarded the Bronze Star and a unit citation for his services.

N. L. Lindquist, M.D., Escanaba

Norman L. Lindquist, M.D., past president of the Upper Peninsula Medical Society, Escanaba surgeons and community leader, died June 19. He was 59.

A graduate of the University of Wisconsin Medical School, Doctor Lindquist completed his internship and a residency in surgery at the Milwaukee County General Hospital. He had practiced in the Upper Peninsula for more than 30 years as a surgeon and otorhinolaryngologist.

Doctor Lindquist also was a past president and past secretary of the Delta-Schoolcraft Medical Society.

Civic groups of which he was a member include the Chamber of Commerce and Rotary International. In addition, Doctor Lindquist was a member of the Escanaba Recreation Board, was a Boy Scout Commissioner, high school team physician, and Selective Service consultant.

He was affiliated with St. Francis Hospital in Escanaba, and his medical fraternity was Phi Chi.

J. J. Miller, M.D., Marne

John J. Miller, M.D., Marne surgeon and otorhinolaryngologist, died June 19 at the age of 76.

Born in Ottawa County, Doctor Miller was graduated from Wayne State University Medical School and took postgraduate training in New York.

He was a member of the Marne Lions Club, the Berlin Lodge No. 248 F & AM, the DeWitt Clinton Consistory, and the Saladin Shrine.

Hospital affiliations include Blodgett Memorial, St. Mary's, and Butterworth.

Doctor Miller was awarded a 50-Year Pin by the Michigan State Medical Society in 1966. He was a Life Member of MSMS.

Max Rulney, M.D., Flint

Max Rulney, M.D., Flint surgeon for 20 years, died March 13 at the age of 62.

Doctor Rulney was graduated from the University of Illinois Medical School in 1930 and interned at Lutheran Deaconess Hospital in Chicago.

He came to Flint in 1946. Previous to that he had served in the Army Medical Corp. He became medical director of Clara Barton Terrace Nursing Home in 1963. Doctor Rulney was affiliated with Hurley, McLaren, and St. Joseph Hospitals in Flint.

Doctor Rulney was a member of the Flint Elks Club 222. His medical fraternity was Phi Lambda Kappa.

L. N. Upjohn, M.D., Kalamazoo

Lawrence N. Upjohn, M.D., Kalamazoo, Director and Honorary Chairman of the Board of the Upjohn Company, died June 2. Doctor Upjohn was 93.

An honorary member of the Michigan State Medical Society, Doctor Upjohn was graduated from the University of Michigan Medical School. For a short time he practiced as a family physician and was a professor of anatomy at the University of Oklahoma.

In 1904 Doctor Upjohn returned to Kalamazoo, his birthplace, and began more than a half-century of service with the Upjohn Company. In 1930 he became president of the Company, a position he maintained until 1944, when he became Chairman of the Board of Directors. Doctor Upjohn retired as chairman of the Board in 1952 and was made honorary chairman.

Vice president and founder of the American Drug Manufacturers Association, Doctor Upjohn was also a trustee of Bronson Hospital, the YMCA, and Senior Citizens Fund, and he served as chairman of the Board of the W.E. Upjohn Institute for Employment Research. He also was chairman of the Tuberculosis Christmas Seal Drive from 1938 to 1940.

In addition, Doctor Upjohn was an active member of the Kalamazoo Amateur Astronomical Association and the American Meteor Society.

Hanlon Heads State Public Health Group; Dempster, Next Leader

Officers for the Michigan Public Health Association, Inc., for the 1967-1968 year are:

President, John J. Hanlon, M.D., Detroit; President-Elect, Andrew T. Dempster, Detroit; Treasurer, Carl F. Schlegelmann, Lansing; Secretary, Ruth Rosenow, Lansing.

Directors for three years are: Linnea Anderson, Ann Arbor; Donald W. McNaughton, M.D., Flushing; and George L. Rouman, Battle Creek.

Two-year directors include: Henry Costantino, Pontiac; Helen R. Swedburg, R.N., Muskegon; and Kenneth Wilcox, Jr., M.D., Lansing.

Elected director for one year are: Claire Co riveau, R.N., Lansing; George F. Sweda, M.D Detroit; and Betty Van Dyke, Coldwater.

Robert E. Rowe, M.D., Port Huron, is MPH. representative to the Governing Council of t American Public Health Association.

Executive secretary of the organization is Ann Lampela, Lansing.

Legislature Approves WMU Health Services Building

Western Michigan University will have a ne University Health Service Building in May 1969. The $2 million self-liquidating project a proved by the WMU Board of Trustees has bee given the go-ahead by the Michigan Legislatur

The three-story building, with 54,000 squar feet of floor space, is being designed to meet t requirements of the University when it reach its programmed maximum enrollment, Richar A. Proos, M.D., Director of Health Services, e plained.

The timetable calls for the start of constructio in March 1968.

The 72-bed capacity in-patient portion of t two-story building will more than triple the beds now available.

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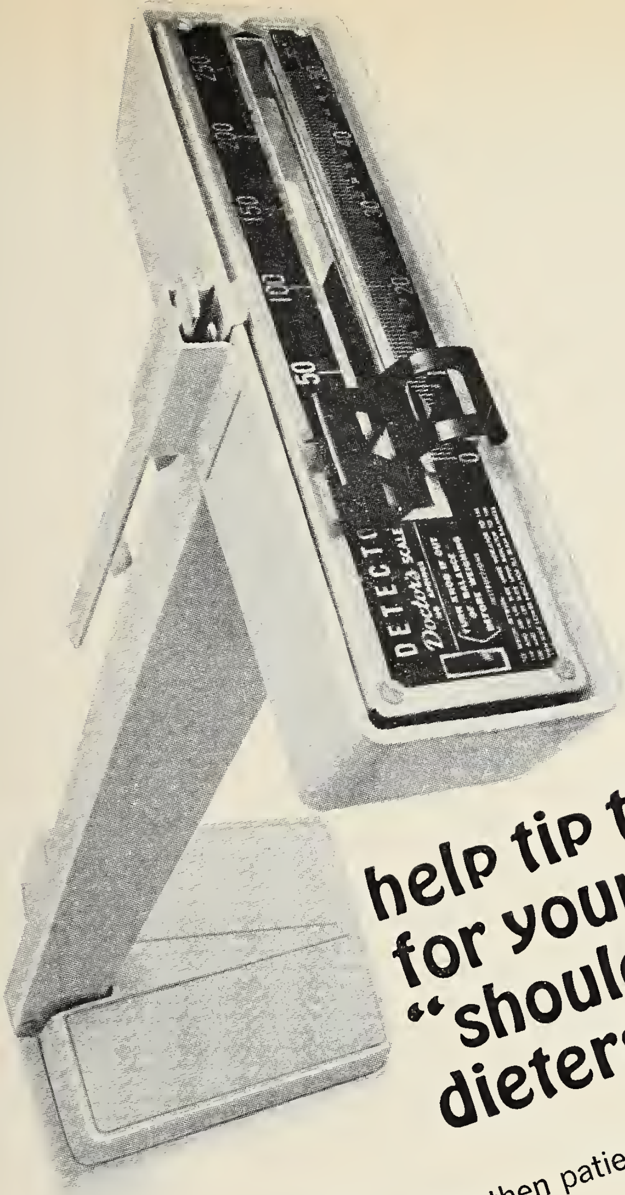

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RURAL CLINIC: in western Michigan needs additional physician with experience or residency training. Community Hospital being expanded. Salary $18,000 - $20,000 depending upon training. Partnership arrangement to follow. For further information contact Dr. T. R. Deur, Deur Clinic, Grant, Michigan 40327. Phone 834-5644.

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MEDICAL DIRECTOR—Opening for a physician in the Central Michigan District Health Department. This district encompasses the counties of Isabella, Mecosta and Osceola. This is a well established district with an excellent public health program. Contact: Kent Gray, Acting Director, Central Michigan Health Department, 1222 North Drive, Mt. Pleasant, Michigan. Phone (517) 773-5922.

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RGES DOCTOR NVOLVEMENT IN MBULANCE SAFETY

The MSMS Council urges every omponent society "to implement s belief that ambulance drivers nd their helpers around the state hould take satisfactory training in rst aid, such as offered by the merican Red Cross."

The Council also asks physiians "to take an active part in uch training and consultation; nd doctors should be active in nplementing satisfactory first aid ourses and should encourage heir respective communities to ofr such courses."

This action was based upon the ecommendation of the MSMS ommittee on Rural Medical ervice, Robert E. Rice, M.D., hairman.

The Council also has taken a tand to "support state legislation, f introduced, to require minimum tandards of training for ambuance attendants and driver-attendnts, minimum standards for quipping ambulances, and the egulation of ambulance traffic." he MSMS Committee on Highay Accident Prevention will draw p reasonable and proper standrds and work with the MSMS egal Affairs Committee in suporting such legislation.

A guest editorial by C. M. Hanen, M.D., Stanton, on ambulances ill appear in the April issue of *ichigan Medicine.*

MD Musicapers

"The Heartbeats provided the nusic at a recent meeting of the akland County Medical Assistnts Society honoring their physiian employers. The music group as composed of Frederick W. Bryant, M.D., Thomas D. Grekin, M.D., Frederick R. Latimer, M.D., dolpho Bruni, M.D., Daniel Barr, M.D., E. William Bauer, Jr., M.D., nd Bruce D. Bauer, M.D.

APPOINTED BY AMA

Recently appointed to the AMA's Council on Occupational Health was S. D. Steiner, M.D., Detroit. Doctor Steiner is medical director of the General Motors Corporation and was a member of the Board of Directors of the Industrial Medical Association from 1963 to 1966.

NEWS — IN BRIEF

ANN ARBOR — The principal address at the 1967 U-M Medical School Class Day Ceremony was given by AMA President Charles L. Hudson, M.D. He came from Cleveland to address the 1967 class of 181. Doctor Hudson was graduated from the U-M Medical School in 1930.

FLINT — Campbell Cutler, M.D., Flint is now local chairman for the 1967 Alumni Fund Campaign of the University of Chicago. Doctor Cutler received his medical degree there.

MARQUETTE — Matthew C. Bennett, M.D., Marquette, is among three Northern Michigan University alumni who received distinguished alumni awards at Commencement ceremonies June 4. Doctor Bennett is a graduate of the Class of 1933 and a native of Marquette.

HILLSDALE — To alert the public of the dangers of accidental poisoning and to advise treatment, the Hillsdale County Medical Society and local pharmacists are jointly promoting the sale of a Poison Antidote Kit. The Society advises that in cases of poisoning the family doctor should be called.

FREMONT — Two Fremont physicians are active on a civic Truth on Fluorides committee with representatives of the Fremont Foundation, Jaycees, and other groups. They are J. Paul Klein, M.D., and Maynard DeKryger, M.D.

Michigan Blue Cross Pays $89,290,822 in Medicare Funds

Michigan Blue Cross has reported that payments of $89,290,822.52 in Medicare funds were paid to hospitals in Michigan for inpatient care for Medicare beneficiaries during the first year.

Wm. S. McNary, Blue Cross president, said that Medicare payments have been increasing in the last few months, even while the program's efficiency is improving. He said that Michigan Blue Cross handled about 160,000 inpatient cases and about 125,000 outpatient bills. This did not include home health care cases or nursing home care.

Maternal Welfare Group Confers

The recent annual Maternal Welfare Committee Conference at Gull Lake combined a business meeting with several addresses.

Special addresses included "Infections in the Newborn Infant and Its Association with Prolonged Rupture of the Amniotic Membranes" by A. Robert Bauer, M.D., and Philip J. Howard, M.D., both of Detroit; "The New Physician" by Don Marshall, M.D., Kalamazoo; and "The Identification of High Risk Pregnancy" by A. C. Rutzen, M.D., Bloomfield Hills.

Invited to the two-day conference were members of the Maternal Health and Child Welfare Committees, chairmen of component society maternal health committees, regional visiting obstetricians and chairmen of regional evaluating committees, members of the Michigan Association of the Profession's Committee on Welfare of the Fetus and Newborn, and the chairmen and secretaries of the Sections on Pediatrics, Obstetrics-Gynecology, and General Practice.

There are 84,200* undetected diabetics in Michigan

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*102nd Annual Session

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Annual Dinner Dance, Wednesday, September 27.

Public Forum on Family Life Education, Thursday evening, September 28.

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REMEMBER SEPTEMBER 27-28-29

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* *The MSMS House of Delegates will meet September 24-25-26. Se Page 1004 for order of business.*

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MICHIGAN STATE MEDICAL SOCIETY VOLUME 66, NUMBER 17 SEPTEMBER 1967

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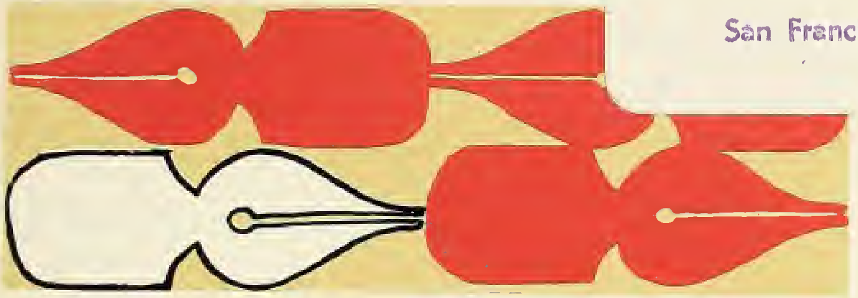


AMONG THE EXCELLENT ARTICLES IN THIS ISSUE:

Family Planning Assistance to Low Income Psychiatric Patients in General Hospitals

What Next? MSMS Urges Dispassionate Study Of Chiropractic Education

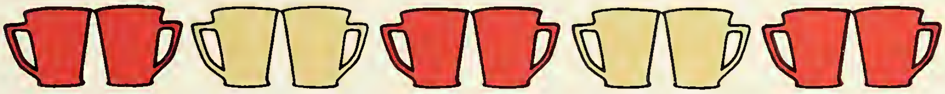
Rising Health Costs: A View from the Congress

Explanation of New Michigan Income Tax

Statements about Family Life Education

Exciting Family Practice Project at Midland

Last President's Page by Doctor Payne



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Reviews of Several Medical Books

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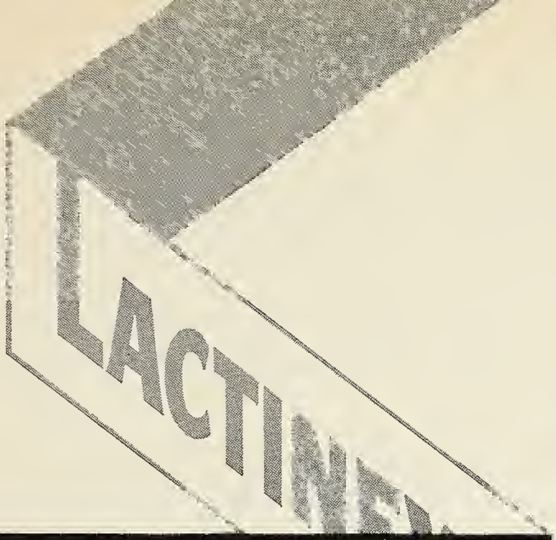

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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Volume 66, Number 17

The cover this month lists many articles that will be of great interest to MSMS members. The design and art work were developed by Dar Davis, graduate art student at Michigan State University.

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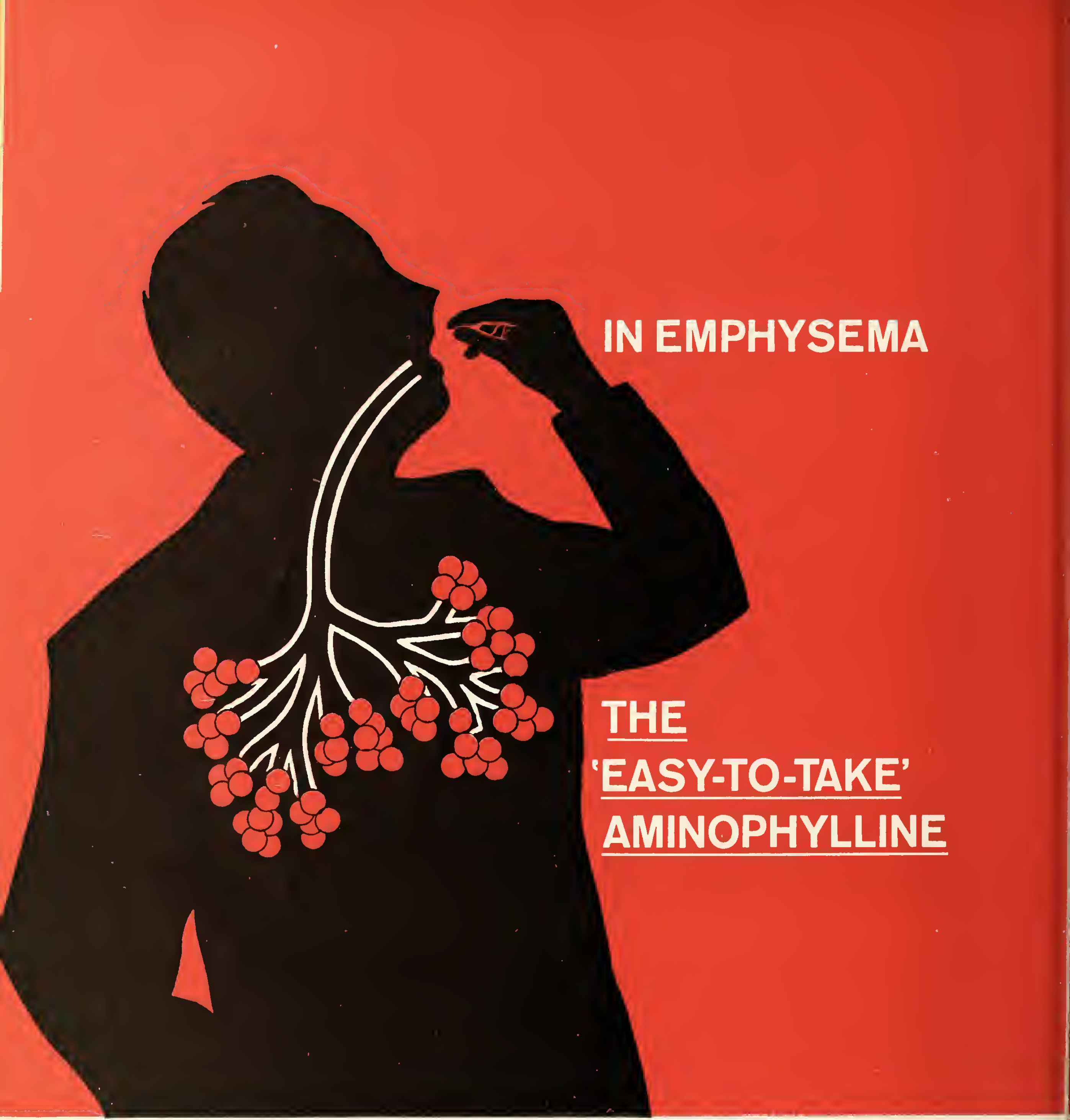

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Michigan State Medical Society
1967 Annual Scientific Session
Grand Rapids, Sept. 27-28-29

The 1967 MSMS Annual Scientific Session will have a new look and a new format.

For the first time, all scientific meetings and exhibits will be on one floor of the Civic Auditorium.

Three concurrent scientific meetings will be held in assemblies adjacent to the exhibit area.

Luncheons each day will feature informal discussion during the meal with guest lecturers seated at various tables throughout the room.

MSMS Sections will present scientific programs of interest to doctor registrants and all scientific meetings will be open to all. Some of the Sections plan receptions and dinner meetings in addition to the scientific program presentation.

The Annual Dinner Dance will be held on Wednesday evening.

The dates are Sept. 27-28-29. Make a note of it.

AMERICAN MEDICAL ASSOCIATION

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Dear Fellow Physician:

These are significant times for all American citizens and for American Medicine. This is a cordial and earnest invitation for you to join us in a re-evaluation of our resources, abilities and opportunities and then with courage and enthusiasm proceed to utilize and develop them.

This will involve us and you individually as participating citizens and faithful physicians, and collectively as more diligent and effective workers in our county medical societies, state associations, specialty groups and the American Medical Association. To this joint effort we invite your enthusiastic and wholehearted cooperation.

The greatest need is probably for more efficient, fruitful communication. We urge you to take a few minutes each month to read the President's Page in your county medical bulletin, state medical journal, and first issue each month of JAMA. We promise you a brief, worthwhile message every month, emphasizing and referring you to things that will interest you. An efficient review of each copy of the *AMA News* will keep you posted on general developments.

You will enjoy and profit from your membership in medical groups in direct proportion to your investment of time in them. We will anticipate seeing you regularly at our medical meetings.

The public relations of Medicine depends on how you and your office aides serve your patients, and how you perform as a citizen.

We will welcome your suggestions at all times, and we thank you sincerely for your cooperation.

Cordially,

Milford O. Rouse, M.D.

Milford O. Rouse, M.D., President
American Medical Association

C. Allen Payne MD

C. Allen Payne, M.D., President
Michigan State Medical Society

president's message

Need Policy, Liaison

As I prepare this, my last message, for the September issue of *Michigan Medicine,* all seems relatively quiet on the national governmental front with respect to medical legislation.

However, during the fall, I am quite sure that organized medicine as well as all physicians will again be faced with multiple propositions that will attempt to change further the private practice of medicine and the present American system of health care.

THAT SUCH CHANGE is inevitable was reiterated by many speakers at President Johnson's June 27-28 Conference on Medical Costs, as well as at other recent presentations. May I quote some recent, representative statements.

Surgeon General Stewart: "The real challenge before the nation is the fulfillment of a newly acknowledged right of every American — the right of access to quality health care."

President Johnson's statement on Medicare: "All the doubts and dire predictions have vanished in the glow of its success. Millions already have benefited and this year we hope to make Medicare even stronger and better."

Social Security Administrator Robert M. Ball: "We are studying whether there are ways in which the patient can be relieved of the hardship arising from his physician's refusal to take an assignment without increasing inflationary pressures on the size of physician's fees."

HEW Secretary John W. Gardner: "I think it is fair to say that the discussions of the past two days have reflected a universal recognition that change is necessary. Essentially, the challenge is before the health profession. They must be willing to re-examine and overhaul long-established practices. The search for new and better and less expensive ways of doing things must be carried on by hospitals, medical schools, community agencies and by the thousands of individual physicians serving the health of the people."

IT IS VERY CLEAR from these and other statements that additional changes in the methods of payment for medical services will occur in the next several years. I believe the pressure for such changes is so great that physicians either in organized groups or individually cannot resist at least some modification of present methods. Furthermore, there will be increasing efforts to relate the quality of medical care to the cost of the service.

Whether such changes are right or wrong, or good or bad, they will occur to some degree. How extensive the changes will be and how quickly they will occur will depend in a large part upon how actively and sincerely the medical profession will participate in the molding, modifying, and development of such changes.

MORE IMPORTANT NOW than ever before is the need for physicians to formulate a unified policy and to develop liaison among medicine, nursing, hospitals, and community and governmental agencies in order to solve this very complex and important problem. This activity need not await implementation at the national level, but can begin in many ways at the state and local levels.

May I again quote HEW Secretary Gardner: "Acceptance of such responsibility by those of the private sector is the best insurance against the government having to shoulder more than its share of corrective measures."

C. ALLEN PAYNE, M.D.

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mail bag

Dear Sir,

re: Abortion — A Complex Issue Today Calling For More Discussion. Michigan Medicine, July 1967, pp. 900-902

In the above named article it is said: "No physician wants to find himself in a hypocritical position."

Later on in the same article it is said: "If the fetus is not a person, on what grounds should any woman who wants an abortion, provided it is not harmful to her, be denied one? On the other hand, if the fetus is a person, on what grounds can someone decide to take its life?"

Does this not point out the very obvious hypocrisy of the therapeutic abortionist and those who would have the laws of the State of Michigan be altered to permit the more widespread taking of innocent human life under the fallacious guise of being "humane"?

Incidentally, the title of the article in question points out the hypocrisy of many medical societies and journals on this subject. Rarely, if ever, is the voice of opposition allowed to appear or be heard. This is indeed ironic, for this stifling censorship is imposed by those who wish to "liberalize!"

Sincerely yours,
John M. Malone, M.D.
Detroit

Please consider the following letter for publication in *Michigan Medicine* in response to an article appearing in the July issue of *Michigan Medicine* on page 865.

During its May meeting, the Michigan State Medical Society Council reaffirmed the definition of the specialist as approved by the 1966 House of Delegates.

On page 867 of the July issue of *Michigan Medicine,* we find the recommendations of the Committee dealing with Resolution Number 22. It is not surprising that the Council concurred with both recommendations, as this definition of a specialist was originally presented to the House of Delegates by The Council in a resolution pre-

(Continued on Page 1069)

DOCTOR,

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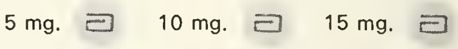

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Desbutal Gradumet contains 2 drugs, each in its own tablet section, combined back to back to form a single tablet. One section contains Desoxyn to suppress the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to soothe the patient and counteract any excessive stimulation. The drugs are released in an effective dosage ratio throughout the day.

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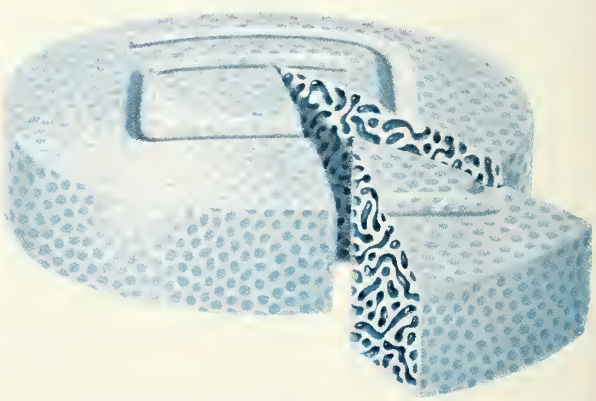

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Here is a partial list of the topics covered:

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Rewards of weight reducing
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Helpful hints
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Each topic is covered on one page in simple and easy-to-understand language. At the back of the booklet, there is a list of 160 foods showing their caloric content.

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This booklet also lists the caloric content of 160 foods.

See Brief Summary on next page.

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ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
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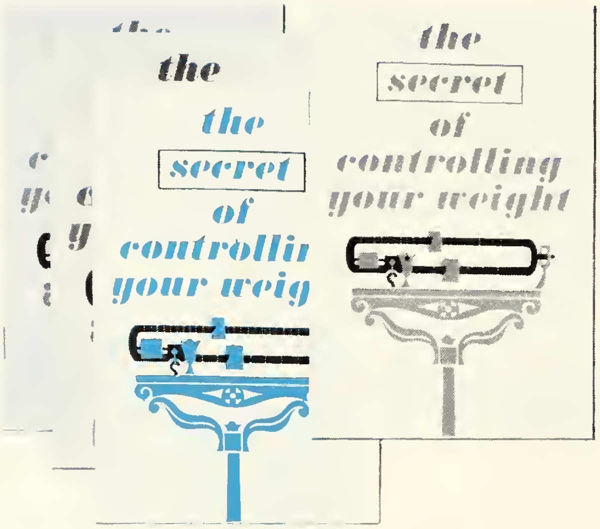

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CONTRAINDICATIONS: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

PRECAUTIONS, SIDE EFFECTS: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and addiction.

Amphetamine side effects such as a headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is usually transient.

701069

Gradumet—Long-release dose form, Abbott: U.S. Pat. No. 2,987,445.

pared prior to the meeting of the House of Delegates.

It is interesting to note that the request of two county Medical societies had been received asking that Resolution No. 22 be rescinded. In addition, I have in my possession a letter from E. G. Cochrane, 1966 President of the Michigan Academy of General Practice, to Blue Shield Board Chairman, John Wellman, M.D., and to the membership of the Michigan Academy of General Practice, pointing out to Doctor Wellman that the definition of a specialist is premature, in view of the present activities of the American Academy of General Practice and he stated at that time that Academy members at that time were being advised not to sign the inquiry sent out by Michigan Blue Shield, regarding doctor's speciality classification.

In addtion, I have communications from the Michigan Society of Anesthesiologists where the Society agrees with the suggestion that the definition be modified to include any person who is a fellow of the American College of Anesthesiology but did not complete a formal residency.

It is possible to become a fellow of the American College of Anesthesiology just by practice time and examination. It is intriguing that the information reviewed at the time of the Committee's Meeting and the people invited to that meeting did not include anyone in a position to render a dissenting opinion or offer any additional information.

I would appreciate the publication of this letter in hopes that other members of the Michigan State Medical Society might communicate to their Councilors and do satisfaction with this definition and in the manner in which the Committee conducted their study of Resolution No. 22.

Very Sincerely yours,
Jack M. Stack, M.D.
Alma

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— Allan Barth
Executive Director
Michigan Hospital
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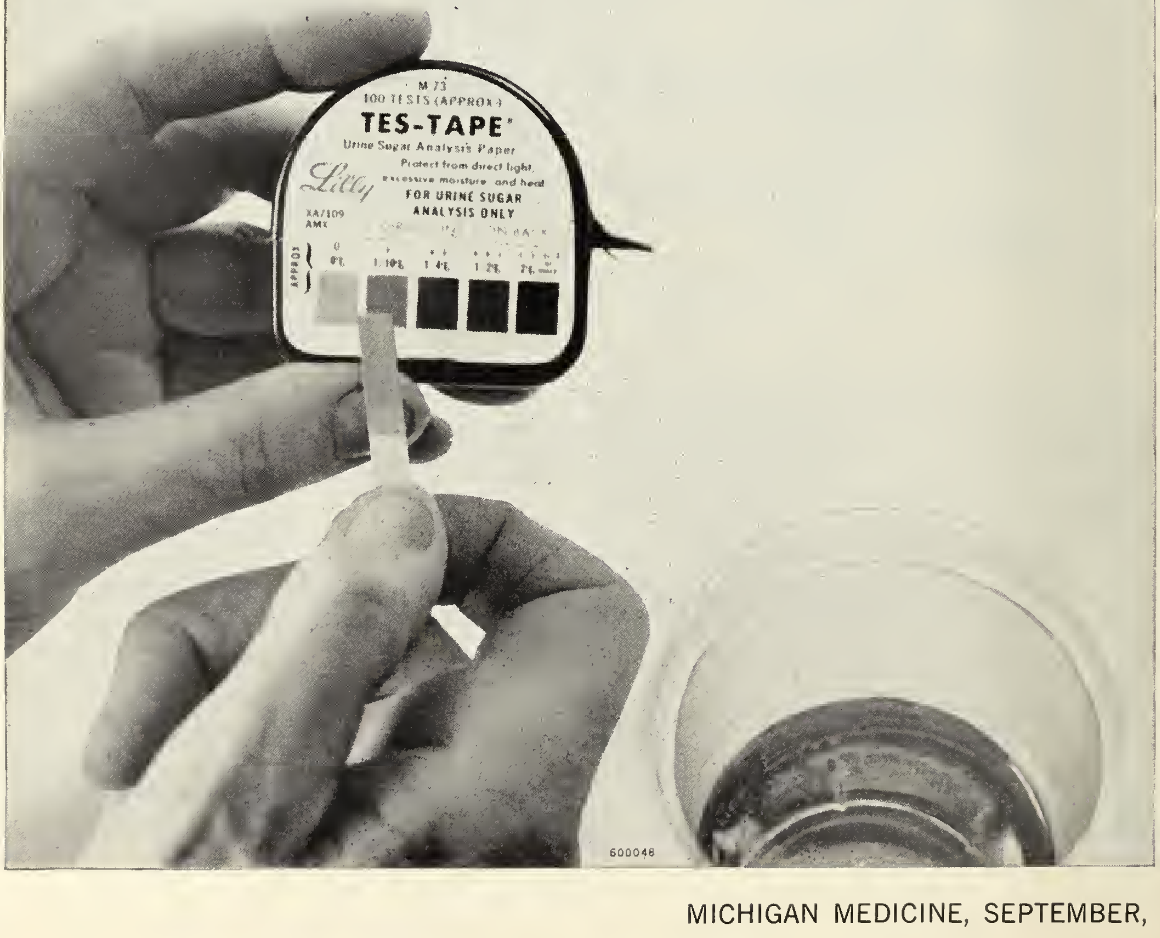
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Say you saw it in Michigan Medicine

Family Planning Assistance To Low Income Psychiatric Patients In General Hospitals: An Exploratory Study

BY GITTA MEIER, M.A.
OHAN W. ELIOT, M.D.
SYBIL HOFFMAN
ALL OF ANN ARBOR

ABSTRACT — The responsibilities for counselng and referral for family planning services asumed by psychiatric personnel were ascertained as part of a survey of such assistance rendered to non-private patients in teaching hospitals. Some of the factors determining the nature and extent of the assistance provided are discussed.

INTRODUCTION

Psychiatrists have long recognized the personal and family stress associated with pregnancy and hild rearing, especially when children are unwanted. Current professional thinking reflects a more general concern with the social implications of unwanted pregnancies and with appropriate means of prevention.[1] This paper explores the opportunities for reducing mental health problems hrough prevention of unwanted pregnancies among low-income, non-private patients in general hospitals, with special reference to psychiatric patients.

The older contraceptive methods have been nconvenient and troublesome for most users, especially for economically and educationally disadvantaged patients. The new oral and intrauterine contraceptives are more acceptable and successful. Because these methods require medical supervision, low-income patients dependent on hospitals with clinics for their medical care must also turn to them for help with effective contraception. Up through the early 60's many hospitals and clinics providing care for such patients have provided little or no contraceptive services. This lack of services has usually been attributed to political or religious pressures on hospital administrations, but there have been other organizational and personal factors affecting birth control services about which less was known and which needed study.

In 1964 the Committee on Family and Population Planning of the Maternal and Child Health Section, American Public Health Association, sponsored a study of family planning assistance for low-income patients in all of the 20 hospitals and associated clinics with obstetrics-gynecology residencies in a midwestern metropolitan area. These hospitals provided obstetric and other medical care for most of the low-income patients in this area. Family planning assistance was broadly defined to include information, counseling, and referral, as well as contraceptive prescription and fitting or rhythm instruction. Lengthy, semi-structured interviews were conducted with administrators, obstetric chiefs, and residents, and responsible staff members in medicine, psychiatry, pediatrics, nursing, and social work, who handled non-private patients. Questions asked were suggested by recent studies relevant to the utilization of birth control[2, 3, 4] and utilization of other private health services by low-income patients,[5] by studies of family planning service in private medi-

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From the Center for Population Planning, School of Public Health, University of Michigan, Ann Arbor.

CO-AUTHORS

DOCTOR MEIER

DOCTOR ELIOT

cal practice,[6, 7] and by studies of current medical school teaching about regulation of fertility.[8]

Family Planning Assistance Provided by Departments of Obstetrics and Gynecology, Relevant to Psychiatric Patients

It is not possible to view contraceptive assistance to psychiatric patients in isolation from contraceptive assistance generally available to non-private patients in the institutions surveyed, especially obstetric patients. This section therefore, summarizes the pertinent characteristics of contraceptive assistance by departments of obstetrics and gynecology. A more detailed description of family planning services in these departments and a rough predictive instrument for surveying such services are presented elsewhere.[9, 10]

Four of the 15 non-Catholic obstetric departments offered comprehensive family planning services routinely. Three of these offered services before hospital discharge, including non-prescription methods pending the six-weeks checkup. Reported proportions of patients who accepted the offer of services in these departments ranged up to 80 percent of all patients delivered. The fourth department did not offer the services until the postpartum checkup and served an estimated 50 percent of all women. Where family planning services had recently been added, it was noted that postpartum returns had increased substantially. Two additional departments stressed family planning, but directly offered it only for medical indications, high parity, or upon patients' requests. One of these last two departments regularly referred patients elsewhere for family planning service rather than giving direct service in the department.

In nine other non-Catholic obstetric departments, family planning assistance was largely left up to the residents, with variable results. In four it was usually offered for medical indications, high parity, and upon the patient's request, and 20-30 percent of the patients received help. In the other five help was not regularly offered even for medical indications, especially in two public hospitals where family planning help was "understood" to be taboo, though not expressly forbidden. Seven of these nine departments referred patients to Planned Parenthood clinics rather than serving them directly, and hence gave no follow-up services. These referrals were mostly done in a perfunctory manner, often omitting addresses and telephone numbers. Obstetricians were skeptica that patients would go to Planned Parenthood clinics located at a distance from them, and in a concurrent study at one hospital, only about one-fourth of the patients referred to Planned Parenthood were arriving there. In these nine hospitals a few residents with prior experience in giving comprehensive family planning services in medical school or internship gave more service than their obstetric chiefs expected, while those with minimal experience tended to do less than expected.

In one Catholic hospital some discretion was allowed physicians to give family planning help through menstrual regulation or by referral outside the hospital. In three others little discretion was allowed due to strict interpretation of the Code of Ethics for Catholic Hospitals. In the fifth Catholic hospital no family planning assistance was allowed, not even rhythm instruction.

Most obstetricians considered serious risk of emotional breakdown as an indication for family planning counseling. Severe postpartum depression was specifically mentioned in this connection. On the other hand, few members of the obstetric clinic staff said they had sufficient time or opportunity for contact with their patients to note stress-producing family situations that might call for family planning help, such as threat of divorce desertion, unemployment, or invalidism.

Physicians generally assumed that social workers were counseling patients about family planning, but few social workers did. Three social work departments encouraged initiative in discussing family planning, while on the other extreme, social workers in three hospitals had actively discouraged patients from seeking family planning help. A similar pattern was encountered among nurses.[11]

There were no statistics kept on family planning services in any of these hospitals in 1964, an indication of the still peripheral and ambiguous position of these services at that time. On the basis of the information available, it was estimated that in 1964 about half of the low-income maternity patients in the hospitals surveyed were offered family planning assistance and that about a quarter to a third actually received contracep-

TABLE I

FAMILY PLANNING DISCUSSION WITH PATIENTS IN PSYCHIATRIC DEPARTMENTS OF GENERAL HOSPITALS

Extent and circumstances of discussing family planning in psychiatric departments.	Socio-economic status of patients.	Number of hospitals.
Attitudes, experiences, problems with family planning often discussed in connection with patients' feelings about their children and future child-bearing in initial history or in later counseling and therapy.	Many well-educated middle class; few low.	3
Family planning rarely discussed (on request only).	Almost all low.	2
Chief of psychiatry thinking that psychiatric social worker and obstetric resident discussed family planning; they disagreed. Obstetric resident believing patients too disturbed on entry to discuss it; he did not see them again.	Almost all low.	1
Family planning never discussed; family planning services very restricted in obstetric and gynecology departments.	Almost all low.	1
No adult psychiatric services. Psychiatrists serving adolescents and their parents in adjacent child-guidance clinics, frequently counseling about family planning, though too late to avert many problems.	Almost all low.	1

ive services, either in the hospital or elsewhere, mostly at Planned Parenthood clinics.

The year 1964 was a period of transition from estrictions on birth control to its active promoion in several of the hospitals serving large numbers of low-income patients.

Nevertheless, important differences between hospitals with respect to the proportion of patients eceiving effective contraceptive assistance are expected to continue. These will be attributable primarily to persistent differentials in return rates or postpartum checkups, to restrictions on service o unmarried patients, to insufficient orientation of clinic staff, and to continuing restrictions on conraceptive services in Catholic hospitals.

Family Planning Assistance Given to Patients by Psychiatric Departments

Six of the hospitals studied gave extensive psychiatric services to low-income patients. Two others gave more limited services. Of these eight, five had psychiatric residencies. Three of the hospitals were private, non-profit hospitals; two were community supported; two were public; and one was part of a medical school.

Discussion of family planning with patients in psychiatric departments varied considerably, as shown in Table I. In all but one of these hospitals, direct family planning services were potentially available to psychiatric patients from their own obstetric departments. However, patients were actually referred to the obstetric clinic in only five hospitals and were occasionally referred to Planned Parenthood clinics or private physicians. There was little checking with either patients or clinics to see if patients got to the Planned Parenthood clinics.

Estimates of patients' needs for family planning help given by chiefs of psychiatric services did not correspond to services available in some cases. For example, one psychiatric chief estimated that only 15-20 percent of women in the child-bearing years on his service needed family planning counseling, yet it was offered frequently. Many of his patients were well-educated, middle-class women. On the other hand, two psychiatric chiefs thought that the great majority of their fertile female patients needed family planning service, for numerous reasons, yet little was given, and their staffs lacked time to devote to the problem. Patients in these other departments were generally poor and uneducated. They had an average of two to three unwanted pregnancies each, and they themselves frequently attributed their mental breakdowns to their last pregnancies.

In this connection it is of interest that only the better-educated patients were reported to have asked whether they should have any more children in view of their mental illness. Other patients often expressed hope of avoiding further pregnancy, but had no confidence in their abilities to do so. Such comments were likely to be treated as indications for contraceptive assistance in only half of these departments.

The differing views of these psychiatrists with respect to indications for offering assistance with family planning are summarized in Table II.

Our respondents differed even more sharply with respect to appropriate indications for therapeutic abortions and sterilization. Their comments ranged from, "Over half of our patients should be sterilized" to "We do not believe in recommending abortion or sterilization on psychiatric grounds alone." In this limited sample psychiatrists least concerned with providing family planning help to their patients most strongly endorsed sterilization.

In the opinion of all the psychiatrists interviewed, family planning assistance to their patients was rendered difficult by the close associations of their sexual conflicts, their emotional disturbances, and their abilities to practice contraception. Additional obstacles mentioned included the following:

1. Ambivalence and guilt about contraception among Catholics.
2. Fatalistic acceptance of childbearing by women of low intelligence, even those with a postpartum breakdown.
3. "Primitiveness" of some patients.
4. Subconscious need to become pregnant.

These problems led psychiatrists at times to discuss contraception with the spouse rather than the patient. Two of the psychiatrists were reluctant to discuss contraception with Catholic patients at all, and two others considered it inadvisable with paranoid or delusional patients.

Promiscuity and pregnancy among adolescent patients was also specifically attributed to subconscious need to become pregnant and to related conflict. Appropriate counseling and contraceptive assistance for patients in this age group were seen as particularly difficult. However, several psychiatrists commented that lack of sex and contraceptive information accounted for at least part of the high pregnancy rate among disadvantaged adolescents.

In 1964 the experience with oral contraceptives for low-income psychiatric patients was still quite limited. Opinions as to the abilities of psychiatric patients to remain on oral contraceptives varied. Most of the comments about problems in practicing contraception related to conventional methods. Intrauterine devices had just begun to be introduced in some hospitals. Psychiatrists stressed their potential value for patients unable to use other methods, but lacked information as to problems that might be expected with widespread use.

Only in the three departments where contraceptive assistance occurred with some frequency (see Table I) did the chiefs of service consider their residents well prepared to discuss family planning with their patients. "Too much so; they are too eager to ask for sterilization," was one comment. Chiefs of service in two of these departments felt confident that their residents' prior training in this area was adequate; the third did not know. Staff lectures and discussions had dealt with family planning in three departments, including two of the above. The subject was raised incidentally in case conferences in two other departments. In one public hospital family planning was said to have been mentioned just once in informal comment concerning an unmarried mother of many children with recurrent postpartum breakdowns. In two hospitals respondents had no staff discussions of family planning at any time.

All these psychiatric chiefs recognized circumstances when childbearing precipitated or aggravated emotional illness. However, such recognition was likely to be translated into departmental action only when certain additional features were present (listed in Table III). The most important of these appeared to be continuing staff contact with the patient and family beyond the acute crisis. In most departments such continuity could not be achieved due to staff shortages, eligibility requirements, and characteristics of the patients themselves.

With respect to the future, four chiefs of psychiatry judged family planning assistance currently provided by their own staffs as adequate to their patients' needs, while two considered most of their patients insufficiently motivated or otherwise incapable of benefiting from family planning assistance. In contrast, the chief of another psychiatric service, where patients previously had received no family planning assistance at all, explored opportunities for systematic assistance at his next staff meeting. The eighth respondent already was pressing for comprehensive family planning services

TABLE II

INDICATIONS FOR FAMILY PLANNING COUNSELING IN PSYCHIATRIC DEPARTMENTS OF GENERAL HOSPITALS

Indications considered by chiefs of psychiatry to justify counseling on family planning.	Number of hospitals.
Child abuse and rejection, request for abortion or sterilization on psychiatric grounds, and marital adjustment problems.	4
Postpartum breakdown, suspected genetic problems, mental retardation, suicide attempts, nervous exhaustion from care of children, prior abortion attempts, previous unwanted pregnancies, recent discharge from mental hospital.	3
Marital and sex problems only.	1

**ABLE III—FACTORS FACILITATING PROVISION OF FAM-
LY PLANNING HELP BY PSYCHIATRIC STAFF TO PA-
IENTS WITH PSYCHIATRIC CONTRAINDICATIONS TO
REGNANCY**

Staff maintained continued contact with patient beyond the period of acute crisis.
. Chief encouraged discussion of family planning during initial interview or subsequent therapy.
. Chief showed awareness of barriers to communication with less-sophisticated persons and compensated for these barriers.
. Chief of psychiatry recognized the indirect effects of unwanted pregnancy on the patient's family and community.
. Chief considered that deficiencies in available contraceptive services contributed to high incidence of unwanted pregnancies among psychiatric patients.
. Family planning clinic was available at or near the hospital.
. Chief (or his wife) or other members of senior staff took part in development of family planning services for low-income patients in the community.

hrough his out-patient gynecology clinic so as to ssure contraceptive assistance for patients and heir families seen in the nearby community child uidance clinic.

SUMMARY AND CONCLUSIONS

The Committee on Family and Population 'lanning of the Maternal and Child Health Secion, American Health Association, sponsored an xploratory study of contraceptive services for lowncome patients in the 20 teaching hospitals of a nidwestern metropolitan area in 1964 in order o determine their current availability, impediments to availability, and changes in availability.

The findings reported here can only suggest the range of views and practices regarding family planning that existed among the staff of general hospital psychiatric services in 1964. A survey of these same departments now almost certainly would show more frequent counseling and referral for contraception, a change largely reflecting innovation and modification outside the psychiatric services.

As far as psychiatric patients are concerned, effective family planning assistance will continue to depend on the quality and continuity of their contacts with staff members. In this respect family planning presents a challenge in the development of follow-up services in community mental health programs.

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SCIENTIFIC ARTICLE

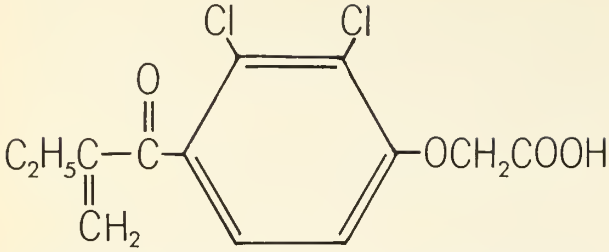

FIGURE 1. Chemical formula of ethacrynic acid.

Use of Ethacrynic Acid, A New Diuretic

BY WALTER D. MEESTER, M.D., Ph.D.
VERNON E. WENDT, M.D.
BOTH OF GRAND RAPIDS

Ethacrynic acid, a new potent diuretic agent, was used in the treatment of patients having edema of various etiologies. The drug produced a prompt and satisfactory diuretic response in all patients treated, including those who were refractory to other diuretic agents.

Ethacrynic acid* (Figure 1) is a potent new diuretic whose chemical structure is unique among this class of drugs. Since 1962 it has had extensive experimental and clinical evaluations and has recently been released by the FDA for general use as a saluretic-diuretic agent under the trade name Edecrin.

It is more potent than the thiazide diuretics and has a clinical effectiveness comparable to or greater than the mercurials.[1] Unlike the mercurials, ethacrynic acid can be administered orally as well as parenterally.

The only other orally active diuretic with a potency approaching that of ethacrynic acid is furosemide (Lasix).[2] Ethacrynic acid and furosemide are similar biologically, but differ in their chemical structure. Both agents induce their saluretic and diuretic effects by acting predominantly on the ascending loop of Henle and the proximal convoluted renal tubule.[3, 4] Ethacrynic acid appears to disrupt the concentrating mechanism, and it partially impairs the diluting operation in the loop of Henle.[3] This action is not shared by the mercurials or the thiazide compounds.

The diuretic response following IV ethacrynic acid occurs within 15 minutes, while diuresis following oral administration may be observed within 30 minutes. The diuretic response reaches its maximum in two hours and persists from six to eight hours. Ethacrynic acid increases the urinary excretion of sodium and chloride and, to a lesser extent, potassium and hydrogen ions.[1] The loss of chloride ions exceeds that of sodium. The drug tends to produce a metabolic hypochloremic hypokalemic alkalosis.[2, 5]

The most important use of ethacrynic acid has been in patients refractory to other diuretic agents. However, it may also be used as a primary therapeutic agent for the elimination of edema caused by cardiac failure, cirrhosis of the liver, or the nephrotic syndrome.

The following is a report of the use of ethacrynic acid in the treatment of patients with edema of various etiologies (Table I).

CLINICAL MATERIAL

Ten hospitalized patients were studied. All had moderate to marked peripheral edema, and three of these had ascites. Five of the patients had failed to respond satisfactorily to a low sodium diet and various combinations of other diuretic drugs. Spironolactone was administered concurrently with ethacrynic acid in six of the patients studied.

Both authors are at Blodgett Memorial Hospital, Grand Rapids. Doctor Meester is director of research at Blodgett. Doctor Wendt practices internal medicine and is the associate director of research at Blodgett and is assistant professor in the Department of Medicine, Wayne State University School of Medicine.

*Ethacrynic acid (2,3-dichloro-[2 methylenebutryl]-phenoxyacetic acid) was kindly supplied as Edecrin® by the Merck, Sharp & Dohme Research Laboratories.

TABLE I

Patient	Age (Years)	Sex	Clinical Diagnosis	Initial Dose of Ethacrynic Acid (mg) (oral or IV)	Maintenance Dose (mg q 6 hours [oral])	Other Diuretics Used Concurrently
W.L.	54	M	CHF*	50 (o)	50	Aldactone
J.S.	60	M	CHF	100 (IV)	50	None
R.S.	48	M	CHF and Laennec's Cirrhosis with Ascites	100 (IV)	50	Hydropres
D.S.	64	M	CHF	50 (o)	50	Aldactazide
G.W.	62	F	Cirrhosis with Anasarca	100 (o)	50	Aldactone
H.R.	74	M	Bronchogenic Carcinoma with Hepatic Metasteses with Ascites	50 (o)	50	Aldactazide
I.W.	71	F	CHF	50 (IV)	50	Aldactazide
C.V.	74	M	CHF and Renal Failure	50 (o)	50	None
B.P.	64	F	Chronic Glomerulo nephritis with Nephrotic Syndrome	25 (o)	25	Aldactone Mercuhydrin
M.S.	73	F	CHF	50 (o)	50	None

*Congestive heart failure

In evaluating the effects of ethacrynic acid as a iuretic agent, the following were measured: body eight, 24-hour urine output, supine blood pressure, temperature, heart rate, respiratory rate, isting blood sugar, serum sodium, potassium, hloride, and carbon dioxide combining power. n addition, hematocrit, hemoglobin, white blood ell, and differential counts were also determined.

As summarized in Table I, the initial dose of thacrynic acid varied from 25 to 100 mg; however, in most patients an initial oral dose of 50 ng was administered. The maintenance dose in ll but one patient was 50 mg every six hours. The average duration of treatment in the patients eceiving a maintenance dose of 50 mg every six ours was three days. All patients were maintained on a low sodium diet (500 to 1000 mg odium per day).

RESULTS

Ethacrynic acid induced a prompt diuresis in ll patients treated and a corresponding fall in ody weight associated with clinical improvement f the edematous state (Table II). The amount f ethacrynic acid required to bring about effecive diuresis ranged from a total of 100 to 300 ng per day. The individual response to ethacrynic cid varied considerably. Some patients lost as nuch as 15 pounds overnight, following the initial ral dose. Other patients diuresed more gradually.

Figure II depicts the diuretic responses observed n two patients with anasarca of different etiologies. After a total dose of 600 mg of ethacrynic acid, patient G. W. rapidly lost 32 pounds in eight days after three intermittent periods of treatment. Patient B. P., however, received ethacrynic acid daily over a period of 29 days, amounting to a total dose of 2900 mg of the drug and only gradually lost a total of 35½ pounds in weight. The latter patient was refractory to both mercuhydrin and furosemide.

In all instances in which serum electrolytes were measured before and after the treatment with ethacrynic acid, we observed no significant changes in the serum sodium concentrations; however, the serum potassium and chloride concentrations decreased in each patient while the carbon dioxide combining power levels invariably increased. Blood pressure, temperature, heart rate, respiratory rate, fasting blood sugar, hematocrit, hemoglobin, white cell count, and differential

CO-AUTHORS

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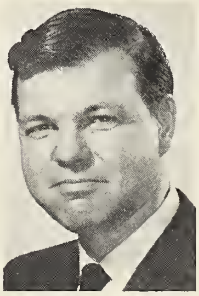

DOCTOR WENDT

count remained essentially at pre-treatment levels.

Side effects related to ethacrynic acid therapy were minimal. Two patients experienced nausea, and one of them had several episodes of emesis. Another patient developed finger and leg cramps, possibly as a result of too rapid diuresis.

DISCUSSION

Our results confirm those of others[1, 5, 6, 7] who have found that ethacrynic acid is a very potent and effective diuretic agent which has a tendency to produce a metabolic hypochloremic, hypokalemic alkalosis. The drug is effective in the presence of various electrolyte abnormalities[1] (Table II) and also in patients with renal insufficiency.[7] It appears to be the drug of choice in patients who have become refractory to organomercurials, thiazides, and other agents, singly or in combination.[7, 8] (Figure II-B.)

Some investigators feel that the increase in potassium excretion may be reduced by concurrent administration of anti-aldosterone agents such as spironolactone or triamterene that impede the sodium-for-potassium exchange in the distal renal tubule. Although spironolactone was administered concurrently with ethacrynic acid to most of our patients, we still observed a considerable decrease in the serum potassium concentrations in thes patients. It is our feeling, therefore, that supplements of potassium chloride should be administered to those patients developing hypokalemia.

Dollery *et al.*[8] reported a fall in mean bloo pressure in a group of hypertensive patients wh were treated for 6-8 weeks with 100 mg of ethacrynic acid daily. We did not observe any significant changes in blood pressure in our patients o short term therapy with ethacrynic acid. However in one patient who received the drug for fou weeks, a decrease of 28 mm/Hg in the systoli blood pressure was recorded.

The maximum effective single dose of ethacrynic acid has been reported to be 150-200 mg.[5] Although we have used an initial dose of 100 mg in two patients, the initial amount should probabl not exceed 50 mg since at higher doses individual patients may have a phenomenal diuresis, even when resistant to other diuretics. Careful selection of the initial dose of the drug is imperative, especially when it is used in conjunction with the thiazides or organomercurial diuretics since these agents, even when they are ineffective by themselves, potentiate the action of ethacrynic acid.[1]

Concerning the toxic effects of ethacrynic acid, the drug is generally well tolerated, and the gas-

TABLE II

PT	Total Weight Loss During Rx (lbs)	Duration of Rx (days)	Ethacrynic Acid mg/24 hrs on day of max. urine output	Max. urine output during Rx ml/24 hrs.	Serum Electrolytes (mEq) BEFORE and AFTER treatment								Blood Pressure before and after treatment		Leukocyte Count before and after treatment		Side Effects	Clinical Course
					NA		K		CL		CO_2							
W.L.	24	4	200	5540	140	137	4.0	3.3	102.6	85.0	26.8	35.5	140/90	138/86	11,200	12,100	None	Improved rapidly
J.S.	25	4	300	7030	143	144	3.9	3.5	101.0	91.0	27.0	39.5	140/84	128/82	9,900	9,300	None	Improved rapidly
R.S.	5½	1	200	4350	134	133	3.8	2.9	95.0	90.0	29.0	29.5	160/80	152/62	10,700	——	Finger & Leg Cramps	Improved
D.S.	16	5	200	4375	126	136	3.7	2.8	96.6	90.0	20.5	22.5	140/80	118/80	19,000	——	None	Improved
G.W.	32	5	200	5590	133	133	2.7	2.4	89.0	72.6	33.0	51.1	120/60	120/70	15,600	——	None	Improved rapidly
H.R.	20	4	200	4110	134	131	4.8	4.3	99.0	85.0	21.0	23.5	152/84	90/50	13,900	——	Nausea	Improved initially but expired later
I.W.	22	2	250	3100+	138	135	5.4	4.7	99.1	89.0	29.2	30.5	150/80	140/72	7,600	9,400	None	Improved rapidly
C.V	23	4	200	Incontinent of large amt.	132	146	4.5	3.5	94.9	89.5	24.6	39.5	90/70	92/68	6,300	9,900	Nausea and vomit.	Improved initially but expired later
B.P.	35½	29	100	2280	127	133	6.6	5.6	96.0	90.0	26.0	27.5	198/54	170/60	12,400	11,200	None	Improved slowly
M.S.	11	1	100	4220	126	——	3.1	—	79.0	——	31.5	——	130/80	128/82	15,600	——	None	Improved rapidly

ric disturbances can be minimized when the drug s taken with or after meals. As with many other iuretics, hyperuricemia may develop, but precipitation of gout is extremely rare.

SUMMARY

Ethacrynic acid, a new oral as well as parenteral iuretic agent, was used in the treatment of ten atients having edema of various causes including ongestive heart failure, hepatic cirrhosis, and nephrotic syndrome. With ethacrynic acid therapy, a prompt, satisfactory diuretic response with weight loss and clinical improvement of the edematous state occurred in all ten patients. Some of these patients were refractory to other diuretic agents. In all instances a decrease in serum potassium and chloride concentrations and an increase in carbon dioxide combining power was observed. Side effects were negligible. Although variation in the individual response to the drug was observed, an initial dose of 50 mg and a maintenance dose

FIGURE 2A

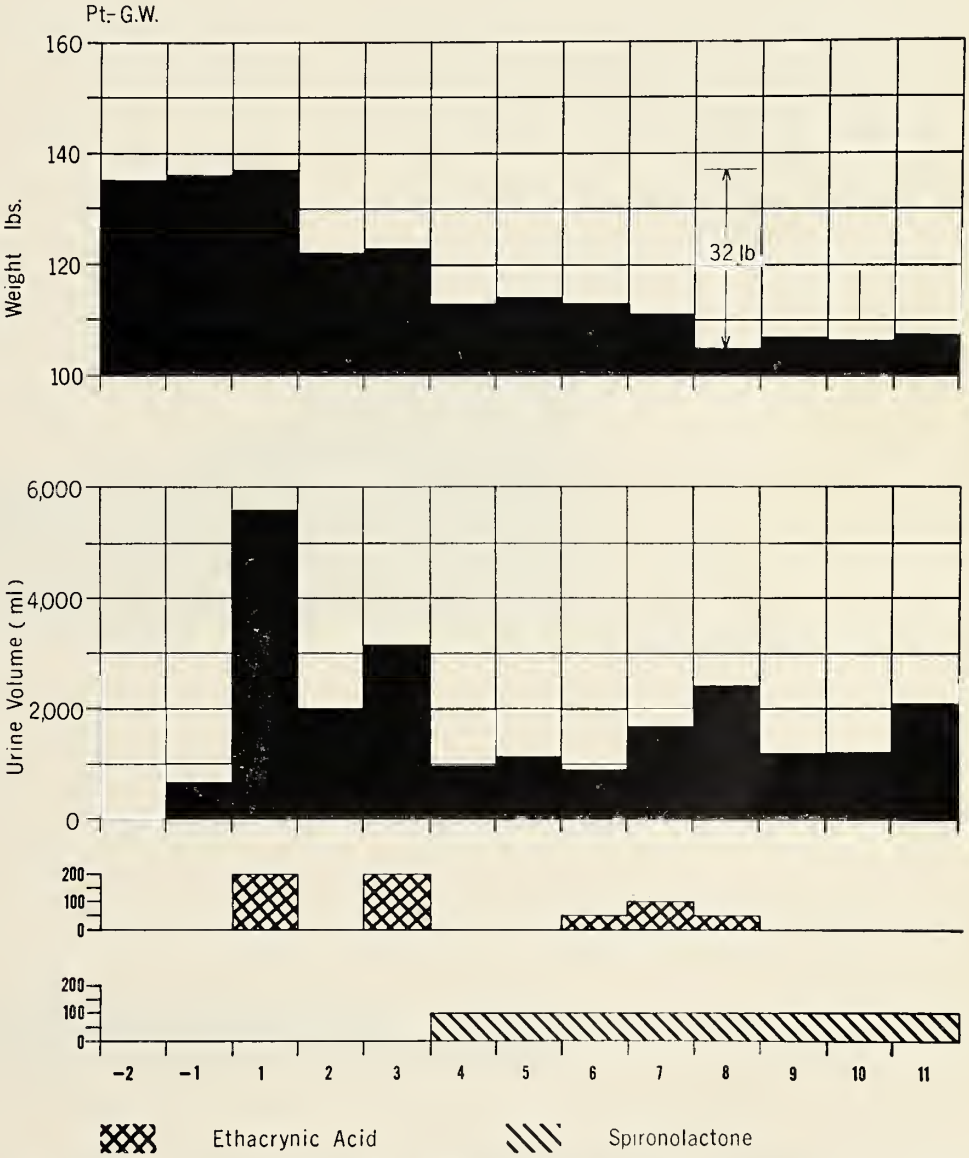

FIGURE 2. Diuretic response to ethacrynic acid in two patients with anasarca of different etiologies. Numbers on the abscissa indicate days of hospitalization. The control days before starting ethacrynic acid are indicated by minus signs. Patient G. W. in A rapidly lost 32 pounds in eight days on intermittent treatment. Patient B. P. in B was refractory to mercuhydrin and furosemide, however, gradually lost 35½ pounds in 29 days of therapy with a low dose of ethacrynic acid. Both patients received spironolactone concurrently.

of 50 mg every six hours appeared to be satisfactory in most patients. The drug is of particular value in the treatment of edematous patients who are refractory to other diuretic agents.

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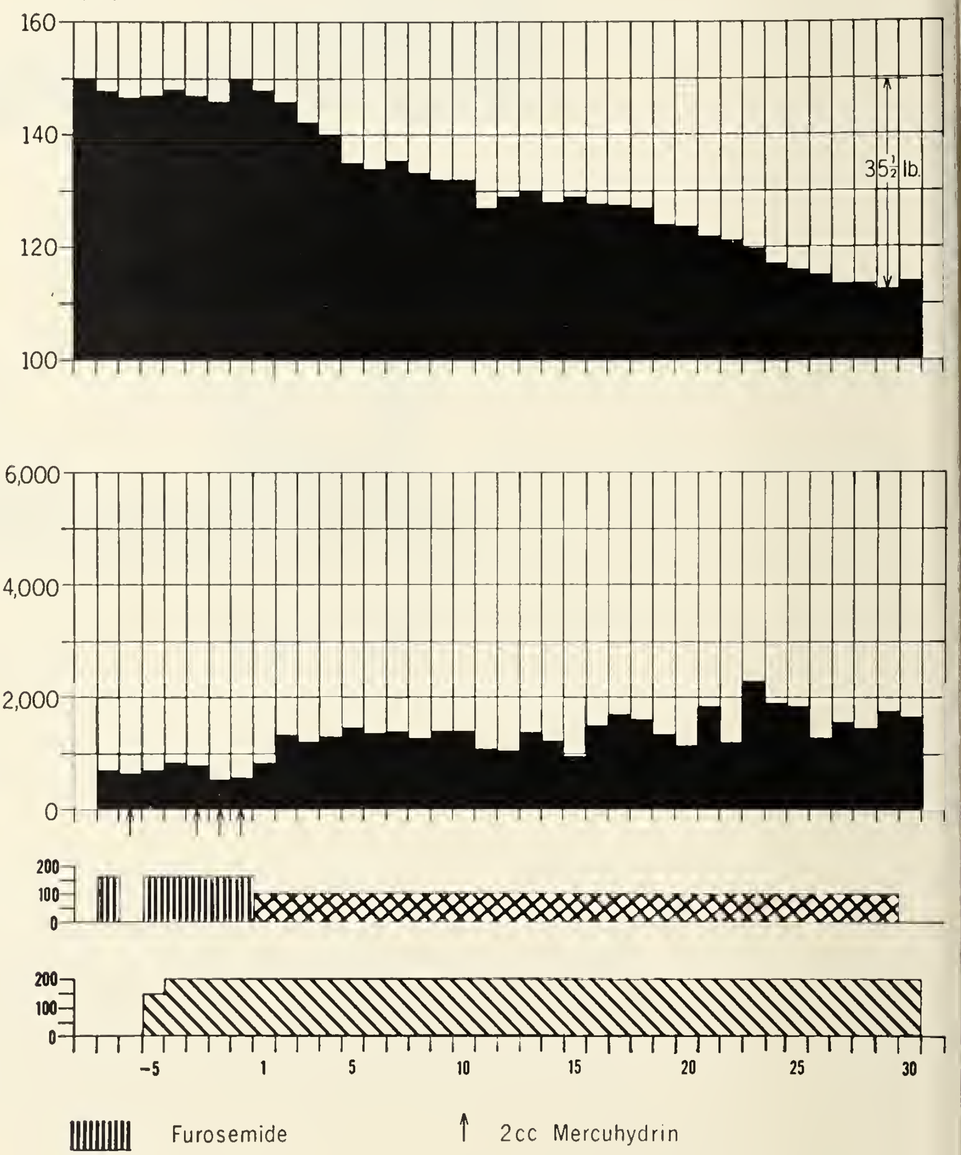
FIGURE 2B (See Legend on Page 1079)



A New Antipyretic Agent

BY CHARLES F. WEISS, M.D., F.A.A.P.
SCOTT T. HARRIS, M.D., F.A.A.P.

ABSTRACT: Although aspirin has been proven o be an excellent antipyretic agent, cases of sensitivity and intolerance occur. Mefenamic acid PONSTEL tm) would appear to have a role as an established antipyretic in clinical pediatrics. Data has been presented to indicate that mefenamic acid has an antipyretic effect similar to aspirin and appears to be equally well tolerated and free of side effects.

Introduction

Mefenamic acid (PONSTEL^{tm}) is a new compound which has been demonstrated by animal laboratory studies to have anti-inflammatory, antipyretic, and analgesic activity. It is a non-steroid, peripherally acting anthranilic acid.[1] Thus, it is pharmacologically similar to aminopyrine and acetylsalicylic acid. Extensive clinical studies have been carried out comparing mefenamic acid to other compounds for the relief of mild to moderate pain.[2, 3]

Compounds having antipyretic activity have obvious application to clinical pediatric practice. Aspirin is the most commonly used pediatric antipyretic in this country. In other parts of the world aminopyrine is commonly used. However, the use of aspirin is not without problems. It is not available in a suspension form. Occasional and varied hypersensitivity reactions and gastrointestinal bleeding are reported.

Pediatric clinical pharmacology studies of mefenamic acid were performer by the authors. These studies included blood level studies, 24-hour urinary throughput studies, and metabolic disposition evaluations. Such trials indicate that the metabolism of this compound in children is similar to that in adults.

After completing the pharmacology studies a trial was designed to evaluate the antipyretic activity of mefenamic acid. Evaluation of the analgetic activity was deferred in children since the results would need to be based on subjective observations. Furthermore, most pain-producing situations in children usually require some additional specific form of treatment. The antipyretic activity is an accurate objective measurement since concomitant treatment is often unnecessary.

Method

This study comparing the antipyretic effect of mefenamic acid with aspirin was performed on a group of institutionalized children. If patients were found to have a temperature elevation above 100°F, they were examined by a physician. If no cause for the temperature, which required some other form of treatment such as antibiotics, was found, those patients were included in the study. Each patient would then receive an initial dose of either mefenamic acid (6.5 mg/kg) or aspirin (in standard dosage) in a suspension form.

Temperatures were recorded one, two, and four hours after medication. The patient was dropped from the trial if definitive therapy such as antibiotics or antipyretic therapy such as sponging was employed.

Results

Patients ranged in age from 2 years, 2 months, to 8 years, 6 months. The weights ranged from 13

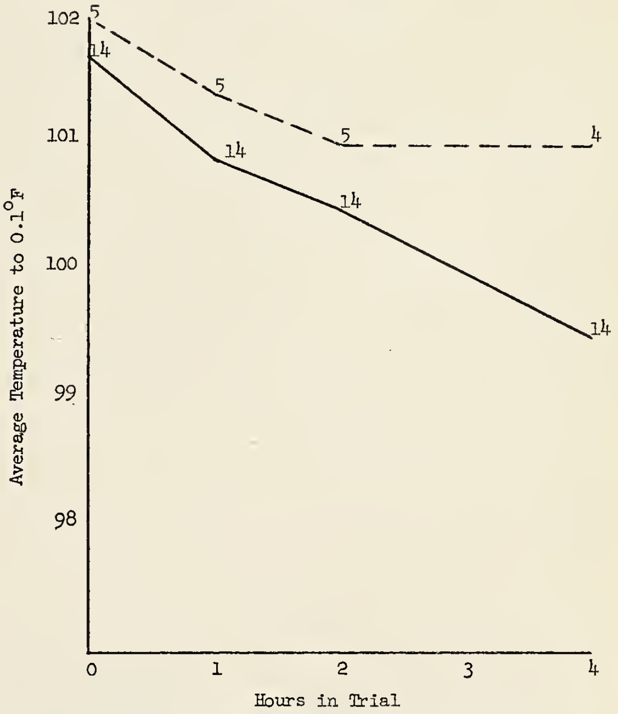


TABLE I
Average temperature during the first day of medication for 15 patients by treatment group.

Legend:
——————— Group A — PONSTEL tm*
– – – – – – Group B — Acetylsalicylic Acid
(The number at each point is the number of observations used for that determination.)
*PONSTEL tm — trade name for mefenamic acid

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to 39 pounds. Mefenamic acid was given 26 times, and aspirin was given 19 times by random list to 30 patients participating in the trial. However, only the initial temperature response for the 30 patients is discussed here owing to the variable natural history of the disease. Eleven patients were excluded since they received concomitant antibiotics or other antipyretic measures.

Only 19 patients met the stringent requirements for inclusion.

The initial temperatures before medication ranged from 101°F. to 103.4°F. The acute disease entities included fevers of unknown origin, colds, neurogenic infectious bladders, and immunization reactions.

The average temperatures at each hour for the first 4 hours are plotted in Table I for the two medication groups. Paired t-testing indicates that the temperature drop is statistically significant at each hour for both treatment groups. The Chi-square test indicates no statistically significant difference between the two treatment groups. We can conclude that mefenamic acid is as effective as aspirin as an antipyretic agent. Close clinical supervision of these patients revealed that both products are accepted and well tolerated.

Conclusions

Although aspirin has been proven through the years to be an excellent antipyretic agent, cases of sensitivity and intolerance do occur. Aspirin is occasionally associated with gastrointestinal bleeding and increased capillary permeability.[4, 5]

In light of the above, mefenamic acid would appear to have a role as an established antipyretic in clinical pediatrics. It has an added advantage over aspirin being in the suspension form.

Data have been presented to indicate that mefenamic acid has an antipyretic effect similar to that of aspirin. Mefenamic acid appeared to be equally well tolerated and free of side effects.

Continuing studies will be performed to further evaluate the antipyretic effect as well as other activity.

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Influenza 1967-68

FROM MICHIGAN DEPARTMENT
OF PUBLIC HEALTH

The Public Health Service Advisory Committee on Immunization Practices advises that substantial numbers of cases of influenza of the A2 type may be expected during the 1967-68 season, especially in eastern parts of the country.

The Committee points out that A2 influenza virus was recovered only from several small outbreaks in the eastern states during the winter and spring of 1966-67.

"No significant amount of Type B infection is likely to occur in the coming year," the Committee report states. This is because in 1965-66 or in 1966-67 most areas of the United States had experienced Type B influenza. Type A outbreaks usually occur every two to three years and Type B every three to six years.

Two influenza vaccines are available for the 1967-68 season. A newly introduced (bivalent) vaccine contains only the A2 and B strains which are currently prevalent. The other (polyvalent) vaccine, similar to that used in past years, incorporates older strains (Types A and A1) as well as the newer A2 and B strains.

The Committee declared that use of the bivalent vaccine should provide a greater degree of protection against current strains of influenza than previously had been possible. This is true because the total activity of the vaccine is divided equally between the current A2 and B strains instead of being divided among other strains as in the polyvalent vaccine.

Again this year the Committee recommended use of the vaccine for persons in groups known to experience high mortality from epidemic influenza. In particular, immunization with bivalent vaccine is recommended for persons in older age groups (persons over 45 and especially those over 65) and individuals with chronic illnesses. The recommendations stressed the need for immunizing patients in nursing homes, chronic disease hospitals, and comparable environments.

"Immunization should begin as soon as practicable after October 1 and ideally should be completed by early December," the Committee's recommendations stated. Persons who require immunization and have not been vaccinated since 1963 should receive a primary immunization series of bivalent vaccine, consisting of an initial subcutaneous dose, followed by a second two months later. Individuals who have been immunized subsequent to July 1963 need only a single booster of bivalent vaccine.

The Older American Act of 1965 — Analysis and Observations

BY C. HOWARD ROSS, M.D.
ANN ARBOR

INTRODUCTION

In 1965 it required the "rough-hewn philosophy" of a Pat McNamara, the "drive" of a Fogarty, combined with the "legislative sagacity and big-brotherness" of a Wilbur Cohen to perfect the Older Americans Act. Such a piece of legislation serves as a conveyor of ethics, prophecy, legislation, finances, directives, rebuttal, and litigation in the courts.

I am thinking of a retired school mistress, rehabilitated as a secretary. The prospects of financial promotion cause her considerable alarm since she fears the "fine" she will suffer as a result of the Social Security limitations on income for the elderly under the age of 72.

Section 101 of the Act, objective Number 5, secures "Opportunity for employment with no discriminatory personnel practices because of age." Thus we begin to witness a sense of foretelling, a hint but not an actuality, that someday the law and the pocket-book will come face-to-face with opportunity, decision, and performance, without artificial restrictions.

From the White House we hear that under the programs of the Act all states and lesser political divisions can move towards a coordinated program of services and opportunities for older citizens. About three-fourths of authorized funds are aimed at the several states to aid in development of Community services. There is, of course, a provision for research, development, and the training of personnel.

The law fulfills the aims of Congress to name a commission in Washington, concerned with the needs of our older generation. It functions as a clearing house for many government agencies dealing with the issues of aging, survivors, disability, insurance, public assistance, health, housing, and employment.

The word "seed corn" has been ascribed to the Act, with the dreamers gazing far into the future. Local communities may alert themselves to their responsibilities and permit Washington to let us think and act for ourselves. Even the grants involved are aimed at the home-town level.

"Older Americans" are defined as having reached age 65. Their number now exceeds 18 million. This number of "Older Americans" is estimated to increase approximately 1000 citizens every 24 hours. Today's elders possess a certain series of talents and needs. Those of tomorrow may graduate into new and different categories. "Problems of the Aged" is a term frowned upon by the AMA and yet the Act employs the wording on several occasions. One must probably resolve such definitions from the standpoint of "needs."

OBJECTIVES

TITLE I

In Section 101 Congress recognizes the inherent dignity of the older individual in our democratic

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This article was requested by the MSMS Committee on Geriatrics and was prepared by one of its active members. Doctor Ross is in private practice in Ann Arbor.

society and emphasizes the responsibility of the national government and the several states and their political subdivisions to secure the following objectives:

1. Adequate income in retirement.
2. The best physical and mental health, without regard to economic status.
3. Suitable housing at realistic costs.
4. Full restorative, institutional services.
5. As indicated above in the introduction.
6. Retirement in health, honor, dignity.
7. Meaningful activity in civic, cultural, and recreational opportunities.
8. Efficient community services.
9. Immediate benefit from health research.
10. Freedom and independence in life-management.

One can readily ascertain that the above objectives are to serve as a sort of biblical text and not to render a sense of legislative compulsion. No one can discover an "or else" insinuation in the principles listed.

SECTION 102

For the purposes of the Act, definitions are submitted:

1. The word "Secretary" indicates the head of Health, Education and Welfare.
2. "Commissioner" designates the commissioner of the Administration on Aging.
3. "State" refers to all states plus Washington, D.C., the Virgin Islands, Puerto Rico, Guam, and American Samoa.
4. "Non-profit organization" is one where no net earnings are yielded to a private individual.

TITLE XI — ADMINISTRATION ON AGING

SECTION 201

A. Creation of the Administration on Aging under HEW.

B. Designation of the Commissioner on Aging, appointed by the President, with the consent of the Senate.

SECTION 202: FUNCTIONS OF OFFICE

1. Serving as a clearinghouse for information dealing with the aged.
2. Assisting the Secretary.
3. Administrating grants.
4. Planning developments, research, and demonstration programs.
5. Giving technical assistance and consultation to the States and subdivisions with respect to programs for the aging.
6. Preparing, publishing, and disseminating educational materials.
7. Gathering statistics.
8. Stimulating effective uses of existing resources

The above summaries are crudely reduced. However, too much wording materially limits the understanding of the functions of office.

TITLE CXI — GRANTS FOR COMMUNITY PLANNING, SERVICES, TRAINING

SECTION 301

Grants to States: $5,000,000 for the year ending June 30, 1966; $8,000,000 for the year ending June 30, 1967; for the next three years such sum as appropriated by Congress for:

1. Community planning.
2. Demonstration programs.
3. Training personnel.
4. Establishment of new programs dealing with recreation, health, counseling, and volunteer services.

SECTION 302 — ALLOTMENTS

1. In general each state will receive 1 percent of the appropriation, with one-half amount allowed to territories.
2. Further appropriations will vary with the number of older persons in each state.

Thus, Michigan could receive grants from (1) and (2). The Secretary possesses much leeway in fund allotments, and there is provided a yearly descending scale of financial responsibility from Washington (75 percent, 60 percent, 50 percent) and total local responsibility after June 30, 1972. It is this provision that keeps local communities "cool" to the Act. An enthusiastic director of a senior citizens guild may be squelched by a city council that watches the purse strings of the future.

SECTION 303 — STATE PLANS

The Secretary will approve a state plan if:

1. A single state agency is designated.
2. Financial participation is provided.
3. There is development of programs plus outlined activities.
4. Consultation is arranged with non-profit organizations.
5. Personnel are secured on a merit basis.
6. Principles are established for priority of projects.
7. Projects are approved, and an opportunity is given for a hearing if projects are denied.
8. Reports are made to the Secretary, and records are kept.

If the Secretary (see Number 7) disapproves of a state plan, an opportunity for a hearing is provided. If he still disapproves, then funds will be cut off. The state that is dissatisfied with such a decision may appeal to the United States Court of Appeals, subject to review by the Supreme

Court of the United States. Needless to say, the "legal drag" could extend for several years.

SECTION 304 — COSTS OF STATE PLAN ADMINISTRATION

A limitation of $15,000 is designated for a state's allotment, with many ifs and provisors attached thereto, plus reimbursements made as the "Secretary may determine." Here the nebulous "Great White Father" stalks into the picture.

TITLE IV — RESEARCH AND DEVELOPMENT PROJECTS

SECTION 401

The Secretary may offer grants to any public or non-profit private agency:

A. To study current patterns and conditions of living of older persons.

B. To develop or demonstrate new techniques such as multi-purpose activity centers.

C. To coordinate community services.

D. To evaluate all approaches that assist older persons to contribute to the strength of our nation.

SECTION 402 — PAYMENT OF GRANTS

The Secretary is the all-powerful determinant and will make no grant where a state agency is established, without prior consultation.

TITLE V — TRAINING PROJECTS — PROJECT GRANTS

SECTION 501

The Secretary is authorized to make grants for the training of personnel by an institution or agency.

PAYMENT OF GRANTS

SECTION 502

Again the Secretary evaluates contributions using his discretion.

TITLE VI — ADVISORY COMMITTEES

SECTION 601

A. An Advisory Committee on Older Americans is established in HEW consisting of the Commissioner and 15 experienced persons not in the employ of the United States, without regard to the civil service laws. The eventual service will extend over a three-year period.

B. Technical Advisory Committees are authorized.

C. Rates of pay are designated.

SECTION 602 — ADMINISTRATION

Consultative services and technical assistance are provided for public or non-profit private agencies. There shall be short-term training and technical instruction. Research and demonstrations are provided as well as dissemination of educational materials and project reports.

The Secretary may utilize any agency of the federal government, with advance agreement, to perform the functions of this Act.

AUTHORIZATION OF APPROPRIATIONS

(TITLES IV AND V)

SECTION 603

In the first year $1,500,000 represents the appropriation. A total of $3,000,000 follows for the second year. Congress will decide the amount of money allowed for the next three fiscal years. (Do not confuse with Title CXI, Section 301.)

The Michigan Commission on Aging has approved the manipulation of Older American Act Funds by issuing a folder of information and recommendations. It emphasizes demonstration projects and the training of personnel and outlines objectives, with eligible programs. Application blanks are available for non-profit groups, and guidelines are offered to meet the merits of the Technical Review Committee. Projects must possess the availability of matching funds to *continue* the *community function* after the *federal grant has terminated.*

The Governor of Michigan has designated the Michigan Commission on Aging as the sole agency in our state to administer funds under Title CXI. The Commission's address is 1101 S. Washington Avenue, Lansing 48913.

CONCLUSION

This law is praiseworthy in that it urges local communities to awaken to the existence of the elderly population. We at the local level can realize the opportunities of initiating seminars and thus create personnel sympathetic to the attributes, capabilities, and needs of the older generation.

The several irritating and picayunish provisions of the law serve as a smoke screen to hide the "sociological goodies" that reside in the Act. Somewhere Grandma is still in her corner, reciting her symptoms, and asking for a place in the sun.

Many cities are suspicious of compromising their future with the "discretion of the Secretary." However, a recent personnel training program in the Ann Arbor - Detroit area was successful in all categories.

Enthusiasts of the Act state that it possesses the combined attributes of "goodness" and "simplicity." I find it difficult to murder goodness with verbiage. However, clarity is a feature that still lingers furtively within the shadows of legislative shrubbery.

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ORIGINAL ARTICLE

The Physician And The National Library Of Medicine

BY LEONARD KAREL, Ph.D.,
BETHESDA, MD.

INTRODUCTION

When the National Library of Medicine was established in 1836 as the Library of the Surgeon General's Office (United States Army), the Surgeon General was authorized to spend $150 for medical literature. Today the Library, located at Bethesda, Maryland, near Washington, D.C., in a five-story contemporary building which it has occupied since 1962, is regarded as the world's largest for biomedicine. Among its holdings of 1,300,000 items in 70 languages are 315,000 monographs, 310,000 bound journal volumes, 285,000 theses, 168,000 pamphlets, and 4,500 reels of microfilm.

The Library provides 175,000 interlibrary loans annually, and of these, 160,000 are photocopies of journal articles not available at the requesting local library. Reference department personnel answer 10,000 personal inquiries, 10,000 telephone inquiries, and 2,000 mail inquiries each year. Requests for 100,000 library items are made by the 25,000 to 30,000 persons who use the reading room each year.

The Library is a major publisher of biomedical bibliographies, e.g., *Index Medicus, Cumulated Index Medicus, Bibliography of Medical Reviews, Biomedical Serials 1950 - 1960, Bibliography of the History of Medicine,* and *NLM Current Catalog.* Among other Library publications are *Medical Subject Headings,* the thesaurus for *Index Medicus, List of Journals Indexed in Index Medicus, National Library of Medicine Classification,* and *Russian Drug Index.*

THE NATIONAL LIBRARY OF MEDICINE

Known for 86 years as the Library of the Surgeon General's Office, the National Library was developed as both a national and an international resource by John Shaw Billings, M.D., Librarian from 1865 to 1895. In 1922 it was renamed the Army Medical Library, and in 1952 it was again renamed the Armed Forces Medical Library. In 1956 under legislation introduced by Senators Lister Hill of Alabama and John F. Kennedy of Massachusetts, it was transferred to the Public Health Service, Department of Health, Education and Welfare, and named the National Library of Medicine.

The Library was established by the United States Congress to assist in the advancement of medical and medically related sciences by the collection, dissemination, and exchange of scientific and other information important to the progress of medicine and public health.

Toward fulfillment of its mission the Library (1) acquires and preserves books, periodicals, films, prints, and other library materials pertinent to medicine; (2) organizes these materials by appropriate cataloging, indexing, and bibliographic listings; (3) publishes and disseminates catalogs, indexes, and bibliographies; (4) distributes materials through interlibrary loans, photographic, or other coyping procedures; (5) provides reference and research assistance; and (6) encourages, promotes, and supports activities to further the progress of medicine and of public health by strengthening existing services and developing new ones.

The Congressional mandate was strengthened recently when, on October 22, 1965, President Johnson signed the Medical Library Assistance Act, Public Law 89-291 of the 89th Congress. In signing the Act the President commented that the nation's medical libraries are a vital link between medical education, practice, and research, and that too little attention has been given to the problem of collecting and sharing scientific knowledge.

The Medical Library Assistance Act is an amendment to the legislation authorizing the establishment of the Library. The Act permits assistance to medical libraries for construction and renovation, for acquisition and improvement of resources, for training of medical librarians and other information specialists, for preparation of publications, for research in medical library sci-

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Doctor Karel is Special Assistant to the Associate Director for Intramural Programs, National Library of Medicine, Bethesda, Maryland.

nce, and for the development of regional medi- al libraries. The Act also authorizes traineeships, llowships, and special scientific projects by in- ividuals or institutions.

Administration of the Act on behalf of the ibrary is done by the Library's Extramural Pro- rams.

The Library today serves as the principal na- ional agent for resources and programs for better- ng communications in medicine and the health iences and is encouraging the existing system of edical libraries to develop into a national medi- al information network. Beginning on July 1, 967, the Library will acquire the Public Health ervice Audio-visual Facility in Atlanta, Georgia. his facility will be renamed the National Medical udio-visual Center and will coordinate a national rogram in biomedical audio-visuals.

Access to the collection is facilitated through an nterlibrary loan program. When libraries request ans through medical library channels, the Na- ional Library of Medicine lends books within he United States and, worldwide, provides single opies of articles from journals which the requesting libraries do not possess and which are not vailable locally. There is no charge for this or ther services except for special photography.

The Library collects materials comprehensively n some 40 biomedical subject categories and se- ectively in many related categories. The collection f over 19,000 serial titles is increased annually y 95,000 to 100,000 items. The Library now stores an estimated 360 million pages, of which 85,000,000 are pre-1870, and at least 10,000,000 more are being acquired annually.

The History of Medicine Division alone has between 60,000 and 65,000 printed works bearing publication dates earlier than 1801. Included in the collection are: an Arabic manuscript of the year 1094 on gastrointestinal disease; a collection of palm-leaf manuscripts from Ceylon, in Singhaleese; works of Hippocrates and Galen; and letters written by George Washington, Benjamin Rush, and Florence Nightingale. Holdings also include 535 incunabula; 33,000 16th-17th- and 18th-century monographs; 1,600 17th-century theses and pamphlets; 2,000 early-American medical works; and an estimated 60,000 prints and photographs.

COMPUTERIZED LIBRARY SERVICES

Efforts of conscientious, busy practitioners to achieve and maintain awareness of the most recent discoveries and applications have often led to many frustrations. The increased volume of medical literature and the number of users have not been paralleled by equivalent growth of medical libraries or of information storage and retrieval methods and facilities adequate to catalog, index, store, and retrieve literature for use by physicians, scientists, and others. Therefore, the Library adopted computerization as a means of assisting, supplementing, and complementing traditional approaches to management of published biomedical literature and pioneered the use of computers for storage and retrieval of bibliographic information.

In January 1964 a computer-based information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the Library.

MEDLARS joins the professional experience of trained literature analysts and researchers with the processing capabilities of a high-speed electronic computer. The literature analysts, using terms selected from a thesaurus of approximately 7,000 terms, *Medical Subject Headings* (Part II of the January issue of *Index Medicus*), characterize each article by assigning to it a number of subject headings or descriptors. Indexed articles are entered into the computer and transferred to magnetic tapes for storage and rapid retrieval. Currently, MEDLARS contains over 550,000 citations to biomedical journal articles published since January 1964. About 55 percent of these are in English.

MEDLARS has improved the quality of the Library's monthly *Index Medicus* and has substantially reduced the time required for the production of other Library bibliographies.

Index Medicus, a comprehensive, monthly subject-author index, now incorporates 180,000 articles annually from nearly 2,300 of the world's biomedical journals. At the close of each calendar year MEDLARS compiles *Cumulated Index Medicus,* a complete listing with cross-references of the citations printed in that year's issues of *Index Medicus.* An abridged edition of *Index Medicus* for physicians' personal use is being planned in cooperation with the American Medical Association.

(MEDLARS does not now include monographs, symposia, conferences, congresses, and proceedings not published in journals.)

The journals listed in *Index Medicus* (approximately 2,300) are selected with the advice of an extramural committee whose decisions are made largely on the quality of the journal under consideration; however, care is taken to assure subject balance. Discussions of journals are based on prior knowledge of the journal and on inspection of it by committee representatives. In addition, the committee is assisted by advice from subject specialists. Comprising the present committee are physicians and scientists, medical editors, and medical librarians.

MEDLARS makes possible rapid machine searches of biomedical journal literature to answer reference questions that cannot be expeditiously handled by manual searches. Machine searches which provide citations to medical literature in specific areas of interest are called "demand bibliographies."

MEDLARS is responding to more than 400 highly specific computer search requests monthly. The requests are coming chiefly from physicians, teachers, and researchers in medical schools, hospitals, universities, and federal research laboratories.

In addition to demand bibliographies, the Library collaborates with professional societies and organizations in the preparation of "recurring bibliographies" — formally published, widely distributed bibliographies in specialized subject areas of broad interest.

These recurring bibliographies are *Artifical Kidney Bibliography; Bibliography of Medical Education; Cerebrovascular Bibliography; Fibrinolysis, Thrombolysis, and Blood Clotting; Index of Rheumatology; Index to Dental Literature;* and *International Nursing Index.*

Although the Library supplies the sponsoring organization with citations retrieved periodically from MEDLARS on film ready for offset printing, the business of publishing and distributing the bibliography — on a non-profit basis — is the responsibility of the sponsoring organization.

At frequent intervals, generally monthly, the Library selects from its demand bibliographies a few of general interest. Announcements of the availability of these bibliographies, called *NLM literature searches,* appear in *Journal of the American Medical Association, Public Health Reports, Journal of the American Dental Association, NLM News,* and other publications including stat journals. There is no charge for these *Searches* Clinicians, educators, and researchers interestec in receiving notices on new *NLM Literatur Searches* may write to the Office of Assistant t the Director, National Library of Medicine, 860 Rockville Pike, Bethesda, Maryland 20014.

62 Bib Requests from Michigan

During the period May 1966 - May 1967, ir clusive, the National Library of Medicine re sponded to 62 demand bibliography requests fror biomedical personnel in Michigan.

Subjects ranged from "Anorexia Nervosa i Children and Adolescents" to "Causes of Deat in Rheumatoid Arthritis," and "Neoplasms i Birds."

The distribution of the 62 requests was:

Michigan State University	1
University of Michigan	24
Wayne State University	1
Western Michigan University	2
United States Government	4
Other (chiefly physicians)	30
Total	62

To enhance effectiveness of MEDLARS the Library has provided its computer tapes and programs to university-affiliated centers which ca make computer-generated demand bibliographie available locally to qualified practitioners, educators, and researchers. Decentralized MEDLARS stations are now in operation or will soon be ir operation at Harvard University, the Universit of Alabama, the University of California at Lo Angeles, the University of Colorado, and the University of Michigan. Others are being considered and as regional libraries, authorized by the Medical Library Assistance Act, are identified, they too, will be provided with a MEDLARS searc capability.

Two MEDLARS centers are in operation outside the United States: In the United Kingdom under a cooperative arrangement between the University of Newcastle-upon-Tyne and the Nationa Lending Library for Science and Technology a Boston Spa, Yorkshire, demand bibliographies are provided by the Lending Library. In Sweden, literature references taken from MEDLARS tapes are being provided by the Karolinska Institute ir Stockholm.

Physicians wishing to obtain demand bibliographies are encouraged to seek the advice of local medical librarians on the suitability of the inquiries and on the preparation of requests t icit the information sought. The use of *Medical ıbject Headings, Guide to MEDLARS Services,* ıd an expression of specific interests will help oid the retrieval of irrelevant citations. Thus, a quest specifying animal experiments will help to sure that citations on human studies will not pear in the bibliography; similarly, specifying single age group will obviate retrieval on all ge groups.

Citations may be arranged alphabetically by nior author, journal title, language, subject headıgs, and year of publication, and each citation ın be printed with the descriptors its indexer asgned to it. Although the computer can print ibliographies on 8½ x 11 in. paper or on 3 x 5 ı. cards, the printout usually is provided on less-stly paper.

The elapsed time between the receipt of a reuest and the mailing of a bibliography is a funcon of the volume of searches requested. At presıt, the elapsed time is about three weeks.

It is important to note that MEDLARS does ot produce abstracts. Furthermore, MEDLARS rvices are not provided for searches which can e conveniently and readily accomplished by using ublished indexes, handbooks, and other reference aterials.

Summary

The National Library of Medicine, now the orld's largest biomedical library, was established y Congress to further the advancement of medical nd medically related sciences by the collection, issemination, and exchange of scientific and other nformation important to the progress of medicine nd public health. It has become an international s well as a national resource for publications and ther items relevant to medical communication nd renders service on a worldwide basis.

In January 1964 a computer-oriented informaion storage and retrieval system called MEDLARS (Medical Literature Aanlysis and Retrieval Sysem) became operational at the Library. This ystem has improved the quality of *Index Medicus* nd other Library-associated publications and has ubstantially reduced the time required for prearation and publication of such publications.

The MEDLARS store of biomedical journal rticles published since January 1964 now exceeds 50,000 and is growing at an annual rate of 180,00 articles, taken from nearly 2,300 journals. Reuests for computer searches come chiefly from hysicians, teachers, and scientists in medical chools, hospitals, universities, and federal research aboratories.

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OFFER REASONS FOR ATTENDING ANNUAL SESSION

Edward F. Sladek, m.d. — For many years I have regularly attended the MSMS Annual Sessions. First of all, it is the only opportunity of the year to meet and talk to medical acquaintances — renewal of friendships. This is the joy of the meeting. Secondly, I have an opportunity to leisurely discuss with a knowledgeable technical exhibitor the feasibility of the use of a new drug or appliance in my practice. Lastly, and most important, I can always pick up a few hints from the scientific sessions that will improve my patient care, and there are always two or three talks in my special field of interest in medicine.

Jack F. Sanders, m.d., Alma — I try to attend the MSMS sessions regularly. The primary reason, of course, is that the scientific sessions are of high caliber, well-delivered, informative, and useful. But almost equally important is that attendance gives me the only opportunity I have to meet my many friends from around the state in the medical profession and in the allied supply organizations. The curbstone consultations and bull sessions are better than many hours of digging in the archives.

Frank Groat, m.d., Grand Haven, says: "I regularly try to attend the MSMS Scientific Sessions. I have found the quality of instruction excellent, comparing very favorably with Interstate Postgraduate Medical Assembly's Meetings.

"In these times of rapid change we need to frequently re-evaluate our treatment and diagnostic routines and our State Meetings give me a convenient opportunity to do this."

Robert E. Medlar, m.d., Jackson, declares, "The Annual Session is a splendid opportunity to renew old medical acquaintances and to keep up with what is happening in a medical way in Michigan."

Special Article Explaining New Blue Shield Programs

BY JOHN C. McCABE, PRESIDENT
MICHIGAN BLUE SHIELD

In Spain, insurance contracts delicately refer to the beneficiary as "la protegida," or "the protected one." The Spanish do of course have the explicit word "beneficiario," but it would offend national morality to suggest, by using it, that one might benefit from misfortune.

"La protegida" is a warm and poetic term but you will not find it in the contracts of Michigan Blue Shield's revised fee and benefit programs. With it, one could not tell who was who. It could apply to subscriber, to Blue Shield itself or, most certainly, to the physician and other providers of health care. The basic philosophy and goal of the long effort to develop these programs has been to protect the private physician-patient relationship through realistic, aggressive action, and in so doing to protect our own existence as well.

The process of development of the programs was an in-depth one which reflected the thinking of a blue-ribbon nine-member cross section of the medical profession, chosen from the 21 physician members of the Blue Shield Board of Directors, working in concert with five lay members of the Board in an Ad Hoc Committee.

All Michigan physicians have received a small brochure which described the environment in which the study was begun, the techniques used in the analysis, and the results, but one feels compelled again to acknowledge the many man hours and selfless effort which these physicians gave.

THE REVISIONS COVER several basic areas.

First is a system of variable physician fees designed to eliminate patient income as a free-determining factor and to hold to the concepts of "customary," "prevailing" and "reasonable" as determining factors, as defined by the House of Delegates of the Michigan State Medical Society at its 1966 session.

Second is a broadly extended benefit program covering all generally accepted surgical procedures, placing no limit upon the number of days coverage for general medical care in the hospital, eliminating the waiting period in most maternity services and liberalizing emergency first aid benefits and consultations.

(The removal of these somewhat synthesized contract limitations and exclusions is not intended to suggest that all controls are off. Instead, the programs are designed to ensure that adequate and necessary services will be covered when they are rendered under accepted standards of medical practice. Rather than a myriad of confusing limitations, a broad program of Utilization Review will be used to prevent abuse and unnecessary expenditure of funds, as well as unnecessary use of facilities.)

Third is a home and office care program covering regular visits in the physician's office, the patient's home and in the hospital outpatient department.

Fourth is a prescription drug program involving legend drugs from a pharmacy, a physician or dentist's own supply, or from a hospital pharmacy, on a full or deductible payment basis.

AUTHOR

MR. McCABE

This article was developed by John C. McCabe, President, Michigan Medical Service, especially for use in *Michigan Medicine*. It is printed in the hope that it will be of interest to Michigan doctors of medicine. Your comments are invited.

Brooker L. Masters, M.D., Chairman
MSMS Publication Committee

"PROTECTION" IS BUILT into every facet of the program.

For the patient, all programs are designed to at once strike down financial barriers to seeking adequate health care, and to seeking it early, before the progress of disease or disorder reaches the costly danger of emergency. They encourage completion of the course of treatment, including full medication.

For the physician, the program should produce greater equity in fee payment levels, more realistic benefit coverage and an opportunity to exercise responsible leadership by showing that the combination of a private prepayment mechanism, in which physicians play a major policy making role, with the practicing medical community, can give the public what it wants and needs.

For Michigan Blue Shield, the programs provide an affirmative and anticipatory protection against government intervention and likewise protect against commercial insurance competition.

THE PUBLIC ITSELF should be added as a fourth "protected one" under these programs. If the medical profession and Michigan Blue Shield are correct in the belief that public health is best served by making government intrusion unnecessary, certainly these programs fill existing gaps in care in practical, realistic fashion. It is one thing for government to rush into a vacuum; it is another for it to attempt to impose itself upon an efficiently working mechanism.

"Blue Shield suddenly has become the doctors' greatest and most effective contact with the federal government," Arthur M. Stevenson, M.D., former president of the National Association of Blue Shield Plans, told the Oregon Medical Group Management Association recently. He said that Blue Shield "with its solidarity, is the doctors' last chance to demonstrate that we can provide the people with superior medical care in the atmosphere of competitive private practice."

Michigan Blue Shield can disagree only with Doctor Stevenson's use of the word "suddenly." These new programs are no sudden thing, nor is government's awareness of Blue Shield's role new.

Study leading to adoption of the programs began in August, 1966, by a committee of physicians and laymen, as noted above, directed by James B. Blodgett, M.D. In addition to their own considerations, committee members utilized field interviews by a professional research organization, direct contact with county medical society leadership around the state, consultations with consumer representatives and reviews of national trends.

There is not room for such detail here, but suffice it to say that the study was no academic exercise. It concerned itself with hard, and at times divisive, questions about what physicians wanted, what industry and labor wanted, what individual and group subscribers desired and what cost levels must be. Many of us reading this know that the committee sought out and questioned physicians throughout the state on an individual as well as county society basis, and was itself questioned.

The most significant change incorporated into the variable fee program deals with the payment mechanism. While many physicians did not express dissatisfaction with C-Plan levels of payment, criticism of the A-B plan levels was universal.

Also, the unrealistic strictures imposed by fixed schedules applying around the whole state without either reflecting variations which should and do exist, nor allowing for periodic adjustments, were apparent.

From the consumer point of view, dissatisfaction with the existing programs did not relate to the fixed fee schedule idea, since a fixed schedule does, in the public mind, help control costs.

THUS THE DILEMMA: equity for the physician and cost control for the consumer.

It becomes quickly obvious for those of us deliberating on these questions that income was a factor influencing physician charge levels.

The variable fee program allowing for variations in charges and by use of the prevailing concept introduces the element of control but with sufficient flexibility so that physicians are not "locked in" ad infinitum to fixed, unchanging levels of payment. The physicians must understand, however, that all charges must be related to the reasonable and prevailing definitions passed last year by the House of Delegates.

Blue Shield's responsibilities to the consumers would not be met, obviously, if we simply paid those charges which each physician decided was customary and, therefore, reasonable without relationship to the totality of physicians' charges in the area.

The committee and Blue Shield management realize well that the variable fee program could evolve, or degenerate, as you will, into, in time, another fixed fee schedule. That is in the future, if it must ever be, but the committee in assessing this possibility indicated that physicians must assess themselves as to prudency.

What happens depends to a tremendous degree on whether adjustments in fees are valid or excessive in this next critical period. If costs escalate unreasonably then the clamor — both private and governmental — for control will probably force some sort of fixed schedule type of payment mechanism. In the past year, physician charges have increased at a greater rate, as have hospital costs, than had previously been so. We all hope that future adjustments are minimal.

Complete and comprehensive medical care is expensive, worthy as that cost may be. If all of the benefits outlined above were incorporated in a group health benefit program immediately, it would be considered extravagant by some sectors. Therefore, while all the programs are available, it is recognized that it would be unlikely to assume that they would be quickly implemented universally. Some flexibility will be necessary, allowing for variations between basic program scope and the fullest program available.

It is my personal belief that the committee's work fits Blue Shield's drive for administrative efficiency, for equity for doctor and patient, for protection of medicine's individual relationships and judgments, for realization of our common goals.

THE NEW PROGRAMS cannot be all things to all men. Each of you may find characteristics which are distasteful and difficult to offset. You will hear criticism of the programs — some with degrees of validity, but some of a type which unfortunately exists in all fields: negative for the sake of being negative.

At Blue Shield we feel that our new programs are a positive response, developed during a difficult period, with most of the answers we need.

One thing is sure. Never before in Michigan or elsewhere has there been an analysis made with greater explorative effort, nor one in which physicians played a greater role.

We feel positive about the prospects of continued and even greater physician support.

Night Leg Cramps . . . Unwelcome Bedfellow
In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]

now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

even in ulcerative colitis...

characterized by:
— diarrhea, cramps, tenesmus
— bloody, mucoid, purulent stools

LOMOTIL® tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.*t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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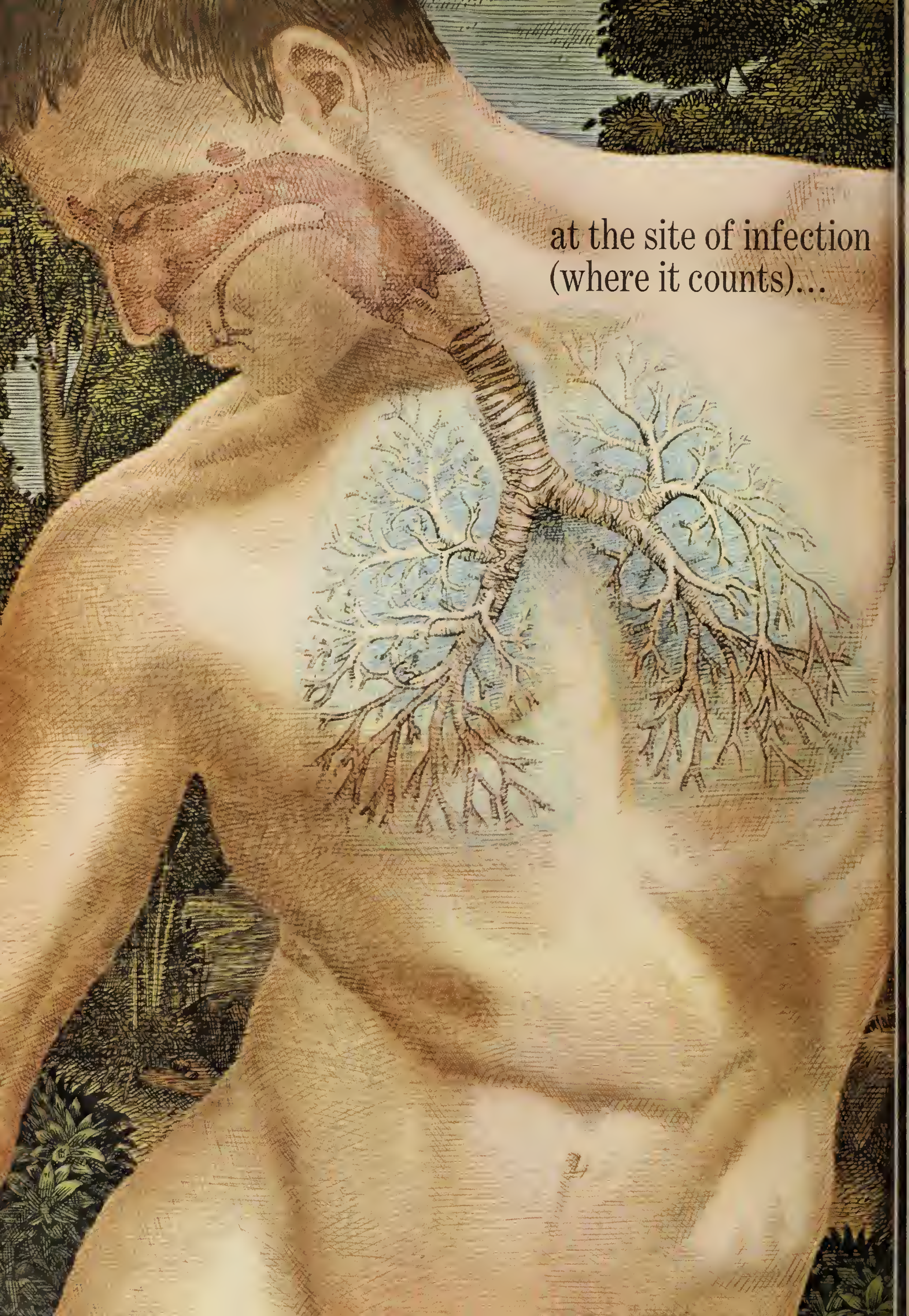
SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeare
be definitely related to use of the drug, laboratory findings w
characterized by increased direct-reacting bilirubin, eleva
alkaline phosphatase levels, negative or weakly positive ceph
flocculation and thymol turbidity tests, elevated serum gluta
oxalacetic transaminase levels, peripheral eosinophilia, and
mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has
been reported in other patients taking prolonged courses of
medication. Patients with chronic infection have been given
to 2 Gm. of the drug daily for periods of two to six months,
patients with rheumatic fever have taken prophylactic dose
0.5 Gm. daily for two years without difficulty. In one group
144 patients who received the drug daily for two years, no ja
dice was noted. It was of interest that members of six of th
patients' families, who were not taking the drug, had episo
of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels w
determined in a group of fifty-four adults and children who t
250 mg. of Ilosone daily for an average of sixteen months
rheumatic fever prophylaxis. The results were compared w
those of a similar group of forty-four patients who received p
icillin. There were no cases of jaundice in either group. Elevat
of SGPT and serum alkaline phosphatase levels during the cou
of treatment was observed in one patient treated with Ilos
and in two patients treated with penicillin. Seven other patie
in the group receiving Ilosone and four others in the penici
group showed elevations in one of the tests at some time dur
administration of the drugs.

Very satisfactory therapeutic results, without toxicity, w
reported in 102 pediatric patients who received short-term (t
day) courses of Ilosone in the treatment of streptococcus inf
tions. Results of liver function tests in these patients w
comparable to those in a similar control group who had recei
penicillin.

Gastro-intestinal disturbances not associated with hepatic
fects are observed in a small proportion of individuals as a res
of a local stimulating effect of the medication on the aliment
tract; however, the normal intestinal gram-negative bacte
flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the
of erythromycin, there have been occasional reports of urtica
skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for O
Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of b
weight, the usual dosage is 5 mg. per pound every six hours;
children twenty-five to fifty pounds, 125 mg. every six ho
(Tablets Ilosone Chewable should be chewed or crushed a
swallowed with water.)

For adults and for children over fifty pounds, the usual dos
of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromy
therapy should be considered.

In the treatment of syphilis, the recommended total dosag
20 to 30 Gm. given in divided doses for a period of ten to fift
days. Close follow-up of the patient is necessary since eryth
mycin drugs have not had adequate evaluation in all stages
syphilis. Examinations of spinal fluid are recommended as p
of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days
recommended. In the treatment of gonorrhea, patients wit
suspected lesion of syphilis should have a dark-field examinat
before receiving antibiotics, and monthly serologic tests sho
be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250
(equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equival
to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packag

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equival
to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packag

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-s
packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to bas
in bottles of 50. [0327

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247:*69, 1
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12:*398, 1
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239:*198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

70

Medical Schools Provide Statements About Family Life Education

The Family Life Education Committee of MSMS is working with many interested groups to improve family life education in the state.

MSMS, the Michigan Youth Council and other groups are concerned about the extent and quality of family life education in the schools. Concern, too, is expressed about the "adequate preparation" of teachers to deal with the complex subject.

Related closely is the medical school instruction on sex and family life organization. Following are statements from leaders of the University of Michigan and Wayne State University medical schools about this subject:

UNIVERSITY OF MICHIGAN:

"Currently spreading interest in sex education, as a means to help overcome the decline in effectiveness of American family life, is particularly evident among medical students. On an interim basis, within the existing curriculum, one-fourth of the weekly lectures to the third year medical students at the University of Michigan have been used to present the relationship of sex including its relationship to family life. In the presentation of these lectures, representatives from Sociology, Psychiatry, Urology, and the Institute of Social Research cooperated with the obstetricians and gynecologists. All twelve lectures were heavily attended by students and student wives.

"While it is not a simple matter to develop a thoroughly balanced course of sex instruction and to make room for it, when completed, within the complex medical curriculum, the faculty is working toward that end. To be truly effective instructional talent from a variety of university divisions within and outside of the Medical School is to be enlisted.

"The now-developing modernized curriculum of the Medical School, will include interdepartmental sequence presentations of broadly related subject matter. One of several such "core" subjects will be "Growth and Development." It is contemplated that here material dealing with sex and family life will find its logical setting. In the meantime the interim plan is to be followed."

WAYNE STATE UNIVERSITY:

"The WSU School of Medicine has recognized the curriculum deficit in medical schools with reference to sex education. An increasing amount of time is now being devoted to this subject. The importance of physicians as resource individuals in family life education in schools and youth organizations is now belatedly being recognized.

"During recent years a section of our course entitled Introduction to Clinical Medicine is devoted to sexuality and the orientation of physicians with regard to sexual attitudes and behavior in order to better equip the physician to serve as an effective counselor in this area.

"The Introduction to Clinical Medicine course is a bridge between the basic science and the clinical years, which are becoming increasingly integrated. The section of the course devoted to sexuality involves faculty from the department of gynecology, pediatrics, phychiatry, and urology. This is generally presented as a collaborative effort in the form of colloquia or panels with free student-faculty exchange.

"Hopefully, this approach will help provide the obvious need for effective instruction in this area in medical schools."

Gerber Research

"Tomorrow
in
Today's Hands"

The evening in 1927 when Dan Gerber attempted to mash peas for his infant daughter's dinner, he started a series of events that gave birth to the baby food business and the Gerber commitment to the commercial production of the best foods possible for infants.

In the ensuing year, the first experiments in the commercial preparation of baby foods began. This led the way to modern feeding practices.

The first Gerber baby foods were marketed in 1928. By 1943, the company was directing all of its attention to baby foods. Today the slogan: "Babies are our business...our only business!"® identifies Gerber throughout the world and millions of mothers know and trust the more than 130 specialized Gerber baby foods. As the company has grown, it has sought the advice and consultation of pediatricians, nutritionists, home economists and mothers.

We believe that the guidance they have provided accounts, in a large measure, for the successful feeding of today's infant population.

But we live in a world of change, accelerated by new developments in science. At Gerber, we have found it necessary and stimulating to keep abreast of scientific change and to participate in the investigation of that area of science which influences human growth and development. Because of such investigation, it is becoming increasingly clear that nutrition plays an important role in biological and physiological development.

Preliminary evidence from world-wide clinical studies suggests that while growth is determined in a large measure by genetic factors, the nutritional environment of the fetus and newborn may markedly affect the future of the child, not only in terms of physical development, but also in terms of mental and emotional capacity.

Through accumulation of such knowledge tomorrow's infants will benefit from the research being done by today's scientists.

Literally—"Tomorrow is in Today's Hands." We are firmly convinced and dedicated to this belief, and, as at the start of our business 40 years ago, Gerber is still committed to providing only the best for babies. In order to do this, we maintain extensive research efforts, in engineering, packaging, food science, bacteriology, chemistry and most important, nutrition.

The Gerber commitment to provide only the best for infants remains the same, but we believe it can best be restated by these words:

"Tomorrow
in Today's Hands"
...through
Gerber Research.

Gerber Products Company,
Fremont, Michigan 49412

Gerber®

BY C. ALLEN PAYNE, M.D.
MSMS PRESIDENT

An editorial entitled "What Next?" appears in the June 1967 issue of the *Federation Bulletin*, monthly publication of the Federation of State Medical Boards of the United States, Inc. Noting that despite the activities of the AMA Committee on Medical Quackery and physicians generally more legal recognition seems to be constantly being gained by chiropractors, the writer suggests that the tenacity of this group is easy to underestimate and he concludes, "All we can say now is, 'What Next?' "

What Next? MSMS Urges Dispassionate Study of Chiropractic Education

A part of the answer to this provocative question seems to have exploded on the scene less than a month after the editorial was written, in the form of two-inch headlines in the Des Moines *Register* (Iowa) reading, "Indict 22 in Exam Cheating!" The full-page article, datelined Sioux City, Iowa, exposes the fact that 22 persons, all but one students or former students of Palmer College of Chiropractic at Davenport, Iowa, have been indicted by a federal grand jury for conspiring to cheat on state (basic) science exams!

> *"All are accused of participating in every violation (using the mails and telephones, stealing, selling or bribing someone to get copies of basic science examinations or having someone other than the designated person take the examination)," said U. S. Attorney Donald E. O'Brien. "The going price for a Basic Science Certificate was 'up to $3,000,' " O'Brien said.*

THE VIOLATIONS ARE said to have taken place between January 1, 1966 and July 13, 1967 and all those indicted are charged with violations carrying a maximum penalty of 20 years in prison and a $20,000 fine. One person indicted is identified as a Michigan man now a student at the National School of Chiropractic in Lombard, Illinois. Another Michigan man indicted is identified as a "former" student at the Palmer College.

More than the State of Iowa is involved; the Des Moines *Register* article says "the 22 are accused of 'devising a scheme to defraud and obtain by false and fraudulent means' Basic Science Certificates from science boards of Colorado, Illinois, Iowa, Nevada, South Dakota and Utah and also from the National Board of Chiropractic Examiners."

The *Federation Bulletin* editorial writer's question is well put — "What next?" He could find additional answers through a review of the pattern of demands made by the chiropractic practitioners upon state legislatures throughout the United States. And there is a clear pattern: recognition as "healing arts" professionals whose services should be permitted in Medicare and Medicaid recipients; status under pre-paid health insurance programs; the right to receive payment for their services to patients covered by Workmen's Compensation; and continuous pressure to persuade the legislatures to write their *beliefs* into their practice acts and thus give these beliefs the implication of validity.

IN OUR STATE OF Michigan, chiropractors have repeatedly sought to have the following paragraph adopted by our legislature as a part of the law: "The philosophy of chiropractic is based upon the premise that disease or abnormal function is caused by interference with nerve transmission and expression, due to pressure, strain or tension upon the spinal cord or spinal nerves, as a result of bony segments of the vertebral column deviating from their normal juxtaposition."

Quoting from MSMS' "Medigram" of June 1, written about the same time as the Federation Bulletin *editorial, "If the legislature declares that this is a legal basis for a 'healing art,' who can guess what chiropractors may ask from it next — and get!*

According to the Des Moines *Register* article, in so far as basic science examinations are concerned, "Chiropractic candidates have complained in the past that the persons scoring the tests are 'especially tough on them' and 'that's the only reason cheating' is sometimes a last resort." In view of the philosophy of chiropractic as presented to the Michigan State Legislature, one cannot but hope that basic science examiners around the United States will be particularly conscientious in examining chiropractic candidates for, as the newspaper article points out, "through reciprocal agreements, many states accept science certificates obtained in other states."

Michigan does license chiropractors by reciprocity, and not a single candidate for a Michigan chiropractic license has taken a Michigan basic science examination in the last three years!

ALL OF WHICH LEADS us back to the provocative question, "What next?" We would strongly suggest again, as we have repeatedly suggested over the years, that the very next thing that *should* happen is a complete, dispassionate scientific study of the extent and quality of chiropractic education, made by a blue-ribbon group capable of evaluating scientific material. Many individuals use the appellation "doctor," but surely the public is entitled to know the credentials of persons claiming that they are the sort of "doctor" who can treat all human illness!

Perhaps the governor of this state, if enough physicians asked him to do so, would see to it that such a long-overdue study was made. Officially, the Michigan State Medical Society has already urged that it be done. The opinions of MSMS' individual members should now be expressed to our chief executive!

DID YOU KNOW THIS ABOUT CHIROPRACTIC?

"1. Chiropractic is a method or system in which the practitioners adhere to the doctrine that disease can be cured by the manual manipulation of the spine. Chiropractors are prohibited by law from prescribing drugs or performing surgery.

"2. Chiropractic schools are not accredited by any recognized educational accrediting body in the United States.

"3. High school or its "equivalent" is the only stated "requirement" for admission to most schools of chiropractic. However, a recent study of chiropractic school admission "requirements" showed that five of seven schools involved in the study granted admission to applicants without high school diplomas.

"4. Nearly 50 per cent of the students in some chiropractic schools attend classes only at night. There are no medical schools in the United States which allow students to attend school only at night.

"5. The majority of instructors in chiropractic schools are not trained or qualified as teachers of the basic sciences, and do not possess college degrees.

"6. Chiropractic spokesmen in 1960 claimed there were 25,000 chiropractors in the United States. The United States census in 1960 showed there were 14,360.

"7. A device (Micro-Dynameter) used by chiropractors for "diagnosing" disease was ruled by a federal court in 1963 to be worthless for "diagnosis." More than 1,000 of the devices were seized by the Federal Food and Drug Administration or surrendered from offices of chiropractors.

"8. Chiropractors are not allowed to practice in any hospital accredited by the Joint Commission on Accreditation of Hospitals.

(The above statements are quoted from a new AMA publication, "Did you know that . . . about chiropractic." For a copy, write to MSMS, 120 West Saginaw, East Lansing, Michigan)

Dear Alumnus:

Your classmates and colleagues will be looking for YOU!

They know you have already completed plans (haven't you?) to attend the Medical Center Alumni Conference October 5, 6 and 7.

After all, *every* alumnus of The University of Michigan who is looking for an excuse to get away can hardly find a better one. The three-day program is planned just for you, your spouses and all the grads of those great years.

As you are aware, this is the University's Sesquicentennial Year—150 years of educational service, and you would like to help us celebrate, we're confident of that.

Just to add a touch of festivity to the three days of scientific programs, fellowship and the opportunity to hear outstanding addresses, we are planning a Special Sesquicentennial Dinner-Dance like we've never had before. And of course, there's the annual picnic and gridiron classic—Michigan takes on Navy, the fun reunions of all classes ending in 2's and 7's, a look at our growing Medical Center and campus, and a firsthand report from Dean William N. Hubbard, Jr., (you'll be surprised at the changes in the Medical Center).

There'll also be special programs for wives and husbands of alumni.

That's not all, of course, but maybe it will jog you into making plans now to be with us October 5, 6 and 7.

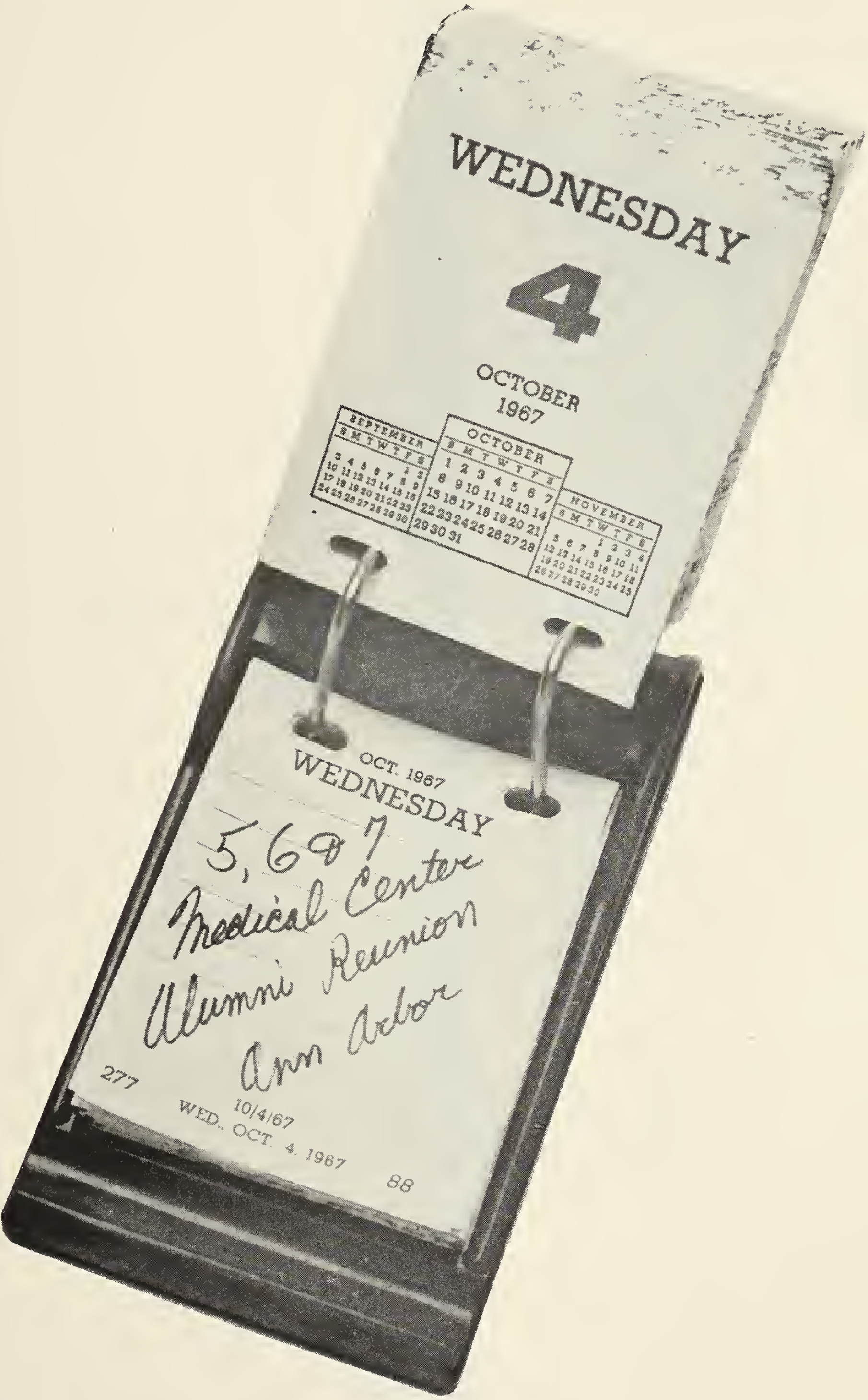
We want to see YOU!

1817

Sincerely,

George W. Morley

George W. Morley, M.D., '49M
Publicity Chairman


WEDNESDAY
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WED., OCT. 4, 1967
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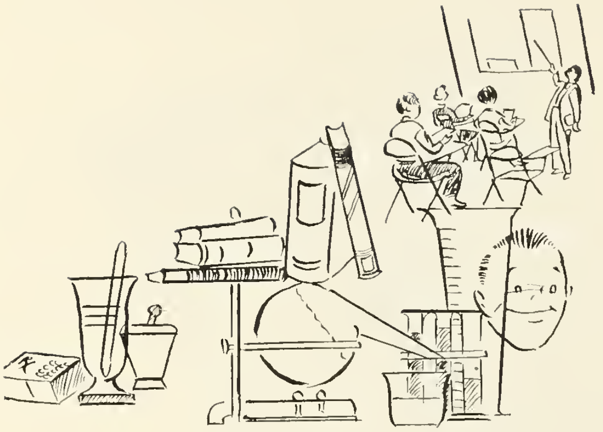


Michigan physicians as parents and community leaders should evaluate the gains being made in education as the number of Michigan school districts has been cut from 1,500 three years ago to the present 807. Doctors also should study possible advantages in proposals to reduce the number further to eliminate all districts which do not provide complete kindergarten-through-twelfth-grade education.

This article was written for **Michigan Medicine** *by Betty Ann Schultz, Pontiac journalist, after an interview with an official of the Michigan Department of Public Education.*

Written comments are invited from MSMS members for consideration in the **Michigan Medicine** *Mailbag feature.*
—Brooker L. Masters, M.D., Chairman
MSMS Publication Committee

Consolidation of School Districts Continues Forward in Michigan

BY BETTY ANN SCHULTZ
PONTIAC

Most educators contend that consolidation of public schools by school district reorganization is one way to improve education for your children. Reorganization evolves from studies, recommendations and public elections, and thereby is carried out by the entire adult community. Supporters of consolidation in Michigan argue that the children can have better education opportunities through improvements in facilities, curriculum, teachers and school financing.

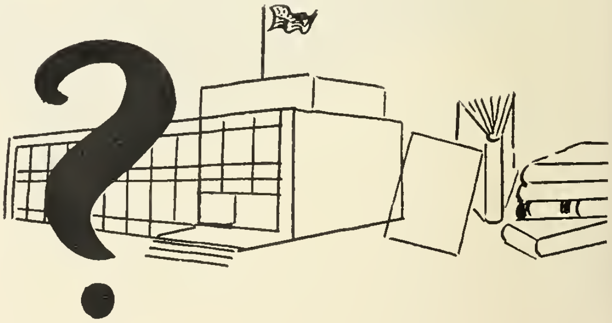
Michigan ranks second among all states in percentage of school district reduction. As of July 1, 1967, Michigan's schools will be grouped into 807 districts. This shows a significant decrease from 1,500 local school districts three years ago and more than 7,000 in the early 1920's.

THE GENERAL PURPOSE of school district reorganization is "to provide adequate education for all students," said David Wood, consultant to the State Department of Education. Although there is no legal or unanimous definition of "adequate," Mr. Wood cited the three most prominent factors: the existence of kindergarten through 12th grade, financial ability and enrollment.

In a district with only a primary school, residents must pay tuition for their children attending high school in another district. More likely, however, previous non-high school districts pay more in taxes when they merge with districts offering high school. With the tax increase, residents should remember they buy better education, Mr. Wood asserted. Another monetary effect of reorganization, he added, is an equalization of the tax burden for education.

The chief reason some districts do not offer high school is because they lack financial ability, explained Mr. Wood. Thus in reorganization, a wealthier district shares its tax base with a poorer district. In addition, available funds are used more efficiently because of less duplication of education-

(Continued on Page 1109)



What's all the fuss about bactericidal?

The ultimate aim in antibiotic therapy is to contain the bacterial colony and eliminate infection. Both 'cidal' agents and bacteriostatic DECLOMYCIN achieve this goal. DECLOMYCIN inhibits susceptible pathogens by stopping their growth; cidal agents affect the pathogens only while they are growing.

Though the two mechanisms differ, the end result is the same—containment of the infecting organism. *However, a very important attribute of any antibiotic is its potency against a broad range of pathogens.* DECLOMYCIN not only offers broad-spectrum potency, but high serum and tissue levels with persistent activity against tetracycline-sensitive organisms. Therapeutic benefits continue for 1-2 days after dosage stops to help prevent relapsing infection.

These are the reasons why so many doctors make DECLOMYCIN their basic broad-spectrum antibiotic. At last count, one billion doses had been administered since its introduction, and the number keeps rapidly growing.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

act. A non-high school district often began lation procedures on its own because it ad a choice of which kindergarten through ade district with which to consolidate.

ever, the public act can be seen to be an tial force for the 344 districts which merged ir own. According to the act, a state com- of seven members appointed by the gov- either approves or prepares reorganization f intermediate school districts (intermediate s replaced the former county districts, num- 60 in Michigan, and serve as administrative nly). The act requires intermediate school s to study their area and submit plans for ization to the state committee. The plans ssure that all districts provide education the 12th grade.

PUBLIC IS integrally involved. The act s that the intermediate district committee e composed of various community adults, at reorganization plans must be approved tors.

public act should be stronger, Mr. Wood ed. He urges legislation to eliminate all which do not provide kindergarten 12th grade education. Of the present , 534 are K-12 districts. As mergers take n Michigan, school officials urge studies ermine the optimum size for adequate and better ways to finance education.

---

st Presidents
ncer Club Honored

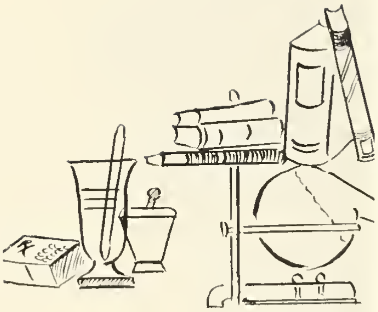
atic proof of the curability of cancer was ed recently in the 17th anniversary of the o Club of Detroit with presentation of to all its past presidents—every one a one- ctim of cancer who not only has defeated ease but regained the power of speech fol- laryngectomy.

club was organized for the rehabilitation ons whose larynxes were removed due to One of its prime activities was the organ- of a speech school, sponsored by the Mich- ncer Foundation, which has passed through rs more than 1,000 laryngectomees who arned to communicate with their fellow- means of esophageal speech.

BIOCHEM GRANT

University of Michigan has received $101,- Biochemical Sciences Support Grant l by the Public Health Service.

grant was one of 93 awarded to institu- y the Division of Research Facilities and es to help meet the nation's growing bio- research needs.



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Continues F

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For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

True broad spectrum

DECLOMYCIN Demethylchlortetracycline should be equally or more effective than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

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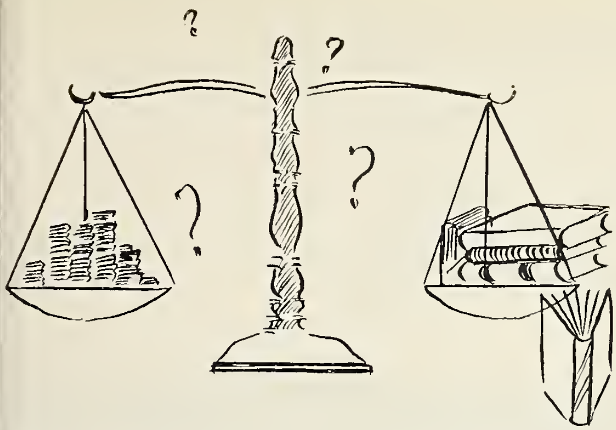

The sketches used with this article are from publications in the Michigan Congress of Parents and Teachers series of "Knowing Our Public Schools" study guides. The artist is Edith O'Berry, Lansing. A copy of the "Knowing Our Public Schools" workbook for citizens may be obtained from the Michigan PTA, 1011 N. Washington, Lansing, Michigan.

al services, facilities and administration, Mr. Wood said.

Larger enrollment as a result of consolidation also provides better education. The state committee on district reorganization recommends an enrollment of 2,000 or more in kindergarten through 12th grade.

Expansion of the districts further means improved curricula, facilities and transportation systems. Larger districts can also attract better teachers.

ONE ARGUMENT AGAINST reorganization is that non-high school districts lose control over their education system when they join with another district. They do not surrender total control but only as much as is spread throughout the district. The semi-mandatory Michigan law urging reorganization specifies that the new school board must represent fairly the residents in the entire district. Non-high school district residents cannot serve on boards of education and vote on educational issues in the district their child attends high school. Although these residents do lose some control over the primary school with reorganization, they gain a new control over a high school.

Other grounds for opposition are a resistance to change and misconceptions of redistricting, Mr. Wood said.

School districts consolidate either according to traditional annexation and consolidation procedures, or to Public Act 289 of 1964. Of the 519 local school districts eliminated from July 1, 1964, to Dec. 31, 1966, only 175 were the direct result of the act. A non-high school district often began consolidation procedures on its own because it then had a choice of which kindergarten through 12th grade district with which to consolidate.

However, the public act can be seen to be an influential force for the 344 districts which merged on their own. According to the act, a state committee of seven members appointed by the governor either approves or prepares reorganization plans of intermediate school districts (intermediate districts replaced the former county districts, numbering 60 in Michigan, and serve as administrative units only). The act requires intermediate school districts to study their area and submit plans for reorganization to the state committee. The plans must assure that all districts provide education through the 12th grade.

THE PUBLIC IS integrally involved. The act specifies that the intermediate district committee must be composed of various community adults, and that reorganization plans must be approved by electors.

The public act should be stronger, Mr. Wood advocated. He urges legislation to eliminate all districts which do not provide kindergarten through 12th grade education. Of the present districts, 534 are K-12 districts. As mergers take place in Michigan, school officials urge studies to determine the optimum size for adequate schools and better ways to finance education.

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17 Past Presidents Of Cancer Club Honored

Dramatic proof of the curability of cancer was evidenced recently in the 17th anniversary of the Anamilo Club of Detroit with presentation of awards to all its past presidents—every one a onetime victim of cancer who not only has defeated the disease but regained the power of speech following laryngectomy.

The club was organized for the rehabilitation of persons whose larynxes were removed due to cancer. One of its prime activities was the organization of a speech school, sponsored by the Michigan Cancer Foundation, which has passed through its doors more than 1,000 laryngectomees who have learned to communicate with their fellowmen by means of esophageal speech.

GETS BIOCHEM GRANT

The University of Michigan has received $101,000 in Biochemical Sciences Support Grant awarded by the Public Health Service.

The grant was one of 93 awarded to institutions by the Division of Research Facilities and Resources to help meet the nation's growing biomedical research needs.

when bursitis hits a 280–lb. tackle, hit back with Butazolidin alka

Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoid
those responsive to routine measures as well as contraindicated
tients. Obtain a detailed history and a complete physical and laborat
examination, including a blood count. The patient should not exce
recommended dosage, should be closely supervised and should
warned to discontinue the drug and report immediately if fever, s
throat, or mouth lesions (symptoms of blood dyscrasia); sudden wei
gain (water retention); skin reactions; black or tarry stools or ot
evidence of intestinal hemorrhage occur. Make regular blood cou
Discontinue the drug immediately and institute countermeasures if
white count changes significantly, granulocytes decrease, or immat
forms appear. Use greater care in the elderly and in hypertensiv

Adverse Reactions: The most common are nausea, edema and d
rash. Swelling of the ankles or face may be minimized by withhold
dietary salt, reduction in dosage or use of diuretics. In elderly patie
and in those with hypertension the drug should be discontinued w
the appearance of edema. The drug has been associated with peptic

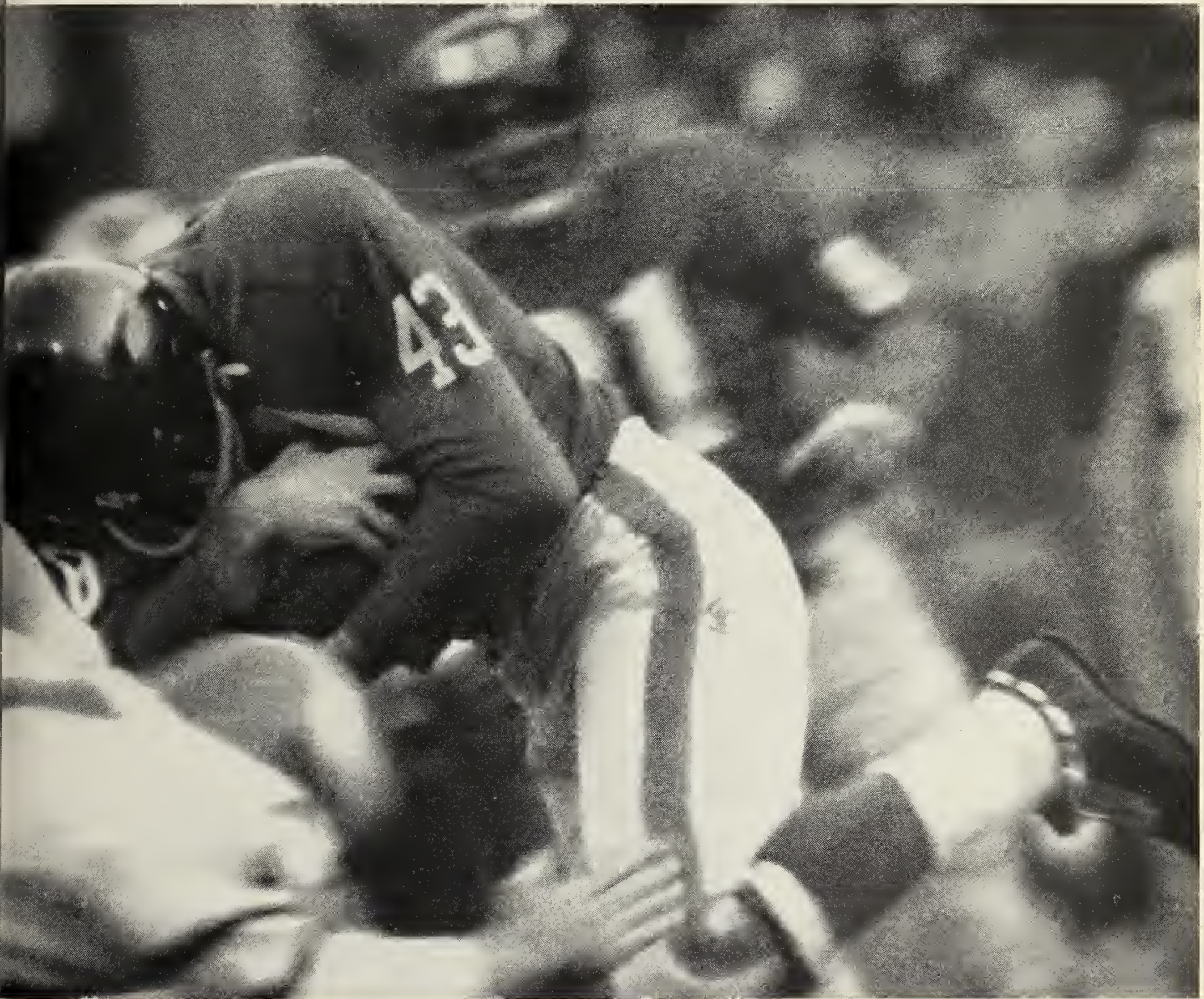
or 280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the gonizing pain of shoulder bursitis.

's not for every patient. Check carefully the Contraindications, Warning and recautions shown below.

nd adverse reactions may occur. The most common are nausea, edema and rash. arely, agranulocytosis has been reported. All adverse reactions are listed below, too.

lay-for-pay or workaday patients—when they come up with shoulder bursitis and your linical judgment indicates Butazolidin alka—go with it.

nd watch the comeback.



er and may reactivate a latent peptic ulcer. The patient should be in-tructed to take doses immediately before or after meals or with nilk to minimize gastric upset. Mild drug rashes frequently subside vith reduction of dosage. However, rash accompanied by fever or ther systemic reactions usually requires withholding medication. urpuric rash has also been reported. Agranulocytosis, exfoliative lermatitis, Stevens-Johnson syndrome, or a generalized allergic re-action similar to serum sickness may occur and require permanent vithdrawal of medication. Stomatitis, salivary gland enlargement, omiting, vertigo and languor may occur. Leukemia and leukemoid eactions have been reported. While not definitely attributable to the lrug, a causal relationship cannot be excluded. Thrombocytopenic ourpura and aplastic anemia may occur. Confusional states, agitation, neadache, blurred vision, optic neuritis and transient hearing loss have een.reported, as have hyperglycemia, hepatitis, jaundice, and several ases of anuria and hematuria. With long-term use, reversible thyroid yperplasia may occur infrequently. Moderate lowering of the red cell ount due to hemodilution may occur. 6509-V(B)R2

Butazolidin® alka

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, New York

Geigy

Petoskey Doctor Among Advisors

State Conducts Study of School Finances And Educational Programs for Students

An equal amount of money for each Michigan student, kindergarten through 12th grade, will not buy equal, high-quality educational opportunities.

Different abilities and educational needs of individual students underscore that "equal opportunity does not mean identical opportunity." J. Alan Thomas, Ph.D., director of the Michigan School Finance Study, believes.

Dr. Thomas' philosophy is guiding a Study group of 25 members in investigations of Michigan's education system and its financial base. The end result will be recommendations for improving the financial system for education.

The Study began last October with a grant of $200,000 from the Michigan legislature upon the request of the State Board of Education. The final report of the Study is due by this coming September. It will comprise the recommendations and background in book form, as well as related data on electronic tape. Dr. Thomas reported that progress is on schedule, and the group is starting to write the final report.

The Study team includes ten staff members, doctoral students, consultants and a 40-member blue ribbon advisory panel of citizens, educators and laymen. Dean Burns, M.D., Petoskey, is the only medical doctor on the advisory panel.

The participation of various community members follows an aim of the Study "to develop cooperation and understanding among educators and citizen groups throughout the state."

"There needs to be public support for the outcomes of the Study, leading to legislation for changes in the manner of obtaining revenue, distributing it and utilizing it for the support of educational programs," Dr. Thomas expressed.

He emphasized looking at the state as a whole when studying the financial aspect of its education system. Thus, some of the problems the team encounters are the sparsely populated outstate areas, the rapidly expanding suburbs and the densely populated inner city, Dr. Thomas explained.

The primary reason the various areas cannot offer equal educational opportunities, he said, is because of unequal local tax bases. In Michigan the local property tax supplies 46.8 per cent of education funds, according to the figures of the National Education Association. The state provides 47.7 per cent, and the federal government 5.5 per cent.

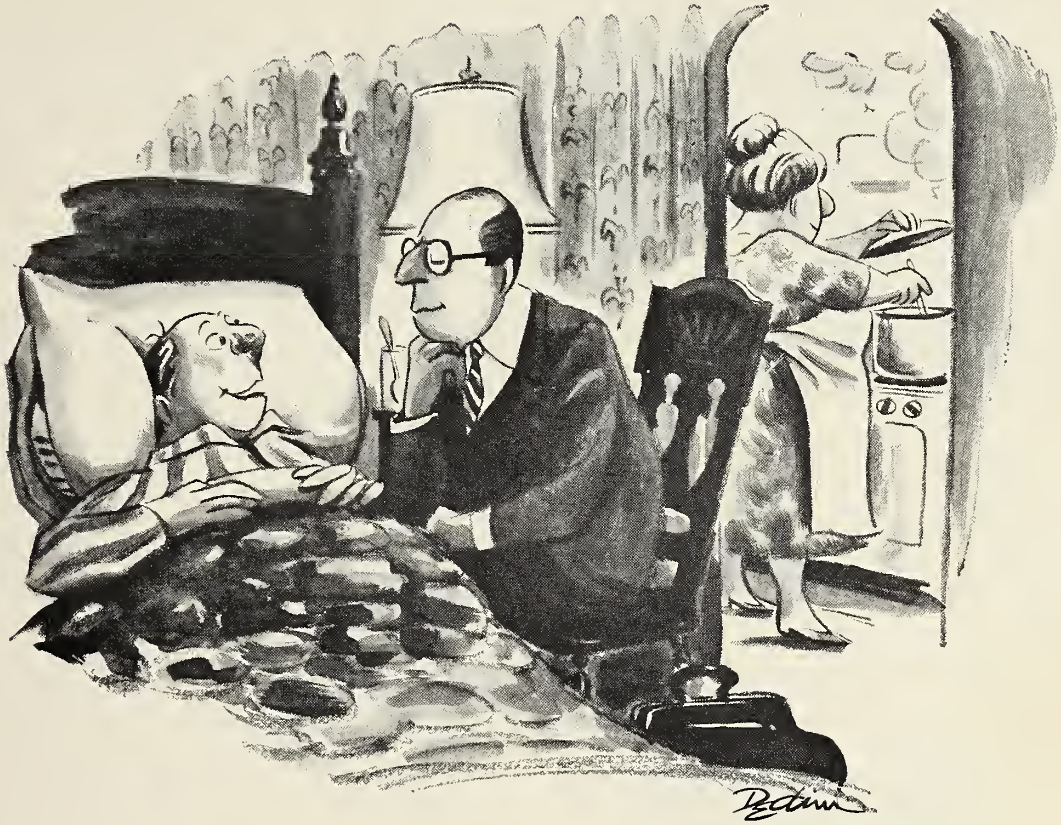
Dr. Thomas expects the process of state education funding to benefit from the Study. He suggests that inadequate information on educational needs is provided for the legislators who annually vote school funds through the State Aid Act. The Study team is examining the costs of education, the present and future revenue sources and education services now provided. The wide range of services to be considered, said Dr. Thomas, includes school lunches, transportation, vocational education courses, and special education for the mentally or physically handicapped.

The researchers are delving into the State Department of Education records, sending questionnaires to school superintendents, and interviewing a sampling of the superintendents. The data will be available on electronic tape for use by government personnel, educators and citizens.

A major concern of the Study, then, is how education should be financed. The team is questioning the percentage of funds from each source, the taxing power of local districts, and the relation of non-public education.

Another significant concern is how to increase the efficiency of the education system. Dr. Thomas is considering here the increased use of educational facilities, more adequate organization of school districts and expanded use of modern teaching methods including television, computers and teacher aides. He also suggested program budgeting — "budgeting according to desired outcomes" — to increase financial efficiency.

Dr. Thomas, associate professor of education and assistant director of the Midwest Administration Center of the University of Chicago, has conducted school financial studies in 13 states, including Ohio, Illinois and Missouri. He studied educational finance at Stanford University where he received his doctorate. "The financial problems of Michigan," he commented, "are very similar to other midwestern states."



"When I couldn't even smell corned beef and cabbage, I decided it was time for you, Doc."

Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

MDPH Center for Health Statistics To Aid Communities

"We have to start delivering information out where the problems are," according to Robert Lewis, Ph.D., new chief of the Michigan Center for Health Statistics of the Michigan Department of Public Health.

The two major goals of the Center, according to Mr. Lewis, are to provide information about community health status and to provide information at the local level about estimates of population change.

An awareness of population changes could be important to physicians, Mr. Lewis observed, because "if he has a specialty the information could help him find a prime area."

With regard to community health status, the Center will work closely with local health departments to help them identify medical problems. The Center will help the local health department to select an area for study and work out a questionnaire relating to the needs and social patterns of an area, as defined by the local area itself."

"The use of the information we collect," he said, "will be up to the local people involved. We will simply provide the information."

Information about population changes will be sent regularly to the medical schools, he added.

This winter the Center will work in six pilot counties establishing the geographical and environmental base for its work through systems such as block coding.

Before beginning work at the Health Statistics Center, Mr. Lewis was professor of Biostatistics at Tulane University's Medical School. He received his doctorate in biostatistics from the School of Public Health at the University of Michigan in 1958.

10-State Tuberculosis Conclave in Michigan

The Mississippi Valley Conference on Tuberculosis and the Mississippi Valley Thoracic Society are holding their annual meeting at the Pantlind Hotel in Grand Rapids, October 4-6.

The theme will develop a "Blueprint for the Future."

Ten other states will be represented at the conference.

MSMS members will be receiving full copies of the program in their mail.

VALIUM®
(diazepam)Roche®

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

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Roche Laboratories
Division of
Hoffmann-La Roche Inc.
Nutley, N.J. 07110

IMPORTANT NEW INSIGHTS INTO HUMAN RESPONSE TO EMOTIONAL STRESS:

New confirmation of the effectiveness of Valium® (diazepam)

Ask your Roche representative to arrange a presentation of this important and fascinating research into certain somatic responses to emotional stress . . . quantitative, objective measurement with double-blind controls.

Please see opposite page for important prescribing information.

William R. Vis, M.D., right, of Grand Rapids, and W. D. Frankforter, Grand Rapids Museum Director, examine an old X-Ray tube in the doctor's office at Gaslight Village in the Museum.

MSMS members interested in medical history are invited to visit the Grand Rapids Public Museum exhibit of a doctor's office during the 1870-1900 period when they are in Grand Rapids for the MSMS 1967 Annual Scientific Session.

Kent Physicians Outfit Old Doctor's Office at Museum

William R. Vis, M.D., Ruth Herrick, M.D., and Fred C. Brace, M.D., all of Grand Rapids, have been furnishing a doctor's office in nineteenth century style as part of the Gaslight Village at the Grand Rapids Public Museum.

Given its formal dedication on May 24, the exhibit depicts how a typical physician's office was set up in the period 1870-1900.

Besides furnishing equipment, the Kent county physicians have given advice on where to place teaching skeletons, cabinets, and bearskin coats in the office.

The teaching skeleton is "George." He was acquired in the 1920s from Ward's Natural Science Establishment in New York by the Museum. "George" has all of his bones and is wired together so that he can be placed into any human position.

"Having a skeleton in the office really impressed people," explained Doctor Vis. "It was mostly for show. Not all doctor's offices had them but many did."

"In recent years 'George' had been relegated to storage because he spooked people," said Frank L. DuMond, who was director of the Grand Rapids Museum for 34 years before he retired recently. Though W. D. Frankforter is now director of the Museum, Mr. DuMond still retains an office in the building and is available for advice and consultation.

Another historically significant item in the office is an X-Ray tube, according to Doctor Vis.

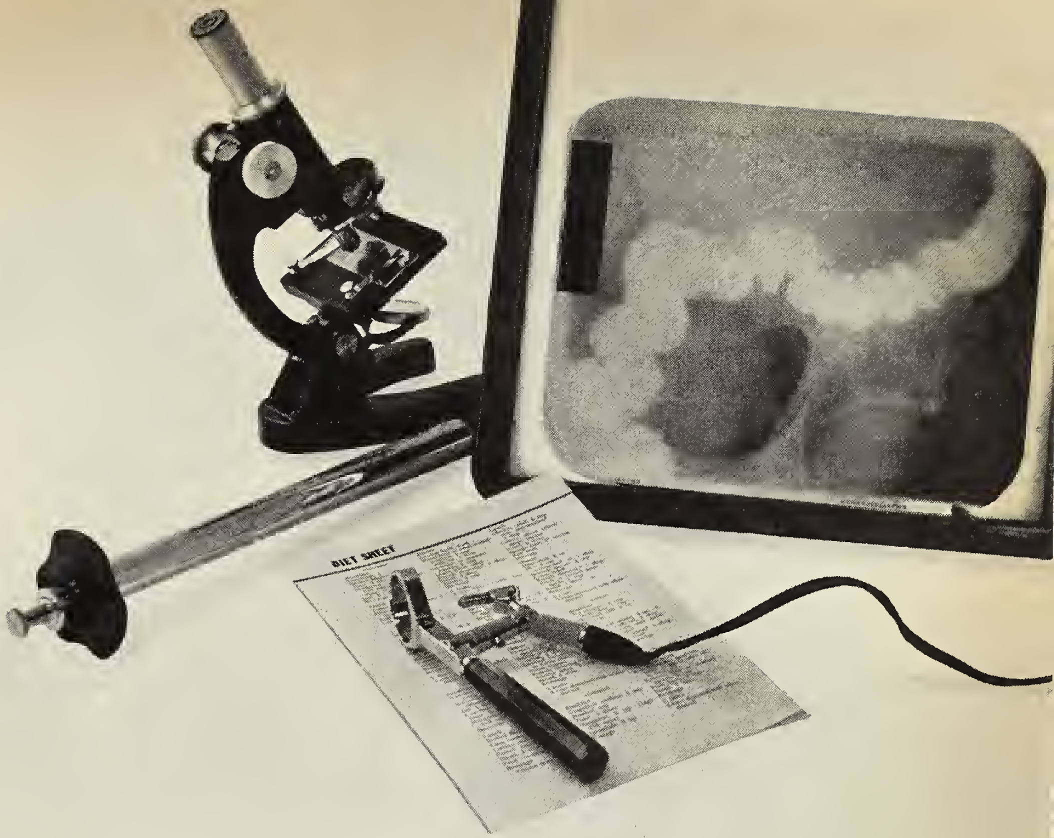
"With a tube similar to the one in the office," Doctor Vis said, "a great Grand Rapids physician, Henry Hulst, an internist, made an important discovery."

"Doctor Hulst cut down the time of X-Ray exposure from one second to one-tenth of a second. When he did it he called a friend in Kalamazoo and told him what had happened. 'I don't believe it,' the friend replied.

"That was in 1911," Doctor Vis continued. "A year later when Doctor Hulst took the tube to Europe they had not even heard of cutting down the time that much. An X-Ray still takes about one-tenth of a second."

A large bearskin coat hangs on a rack near the door of the office. "In those days a doctor had to go out in all kinds of weather," Doctor Vis explained. "He often had a buffalo robe in his carriage as well."

Along with the skeleton, X-Ray tube, and bearskin coat the office features many other items of historical interest including spitoons, an operating table, a doctor's pill case, surgical instruments, and antique furniture of various kinds.



in digestive disorders:

B and C vitamins aid therapy. Nausea, vomiting, and severe diarrhea may seriously interfere with the digestion and absorption of nutrients. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, may help meet the needs of these patients. In digestive disorders, as in many stress conditions, STRESSCAPS vitamins aid therapy.

STRESSCAPS

Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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Winthrop

announces

a breakthrough in the control of pain

Talwin®

brand of
pentazocine
(as lactate)

a potent, injectable non-narcotic

For every physician who has ever prescribed morphine

Talwin is the new potent non-narcotic injectable analgesic which is indicated for relief of all types and degrees of pain in acute and chronic disorders. Talwin 30 mg. is usually as effective an analgesic as morphine 10 mg. or meperidine 75 to 100 mg., but needs no narcotics controls. The duration of action of Talwin may sometimes be less than that of morphine.

Talwin is relatively free from adverse effects of morphine, such as constipation, urinary retention, or severe respiratory depression.

It has been used, in varying dosages, in over 12,000 patients for relief of pain of medical disorders, of active labor and postoperative pain; also for preoperative or preanesthetic medication, and as an adjunct to anesthesia.

A brochure incorporating analyzed information on Talwin is available. The completeness of the information will permit you to evaluate the role Talwin can play in your practice.

You can depend on Talwin to relieve pain:

WHATEVER the intensity of the pain
the cause of the pain
the site* of the pain
the duration of the pain
the chronicity of the pain
the age† of the patient

Talwin does not require a narcotics prescription

The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally." (*WHO Tech. Rep. Ser.*, No. 343, 1966, p. 6.)

It is our sincere belief that the discovery of Talwin by Winthrop Laboratories will be of great value to you and your patients for whom you may have to prescribe a potent analgesic.

*Talwin should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.

†Until sufficient experience is gained, it should not be administered to children under 12 years of age.

Talwin—brand of pentazocine (as lactate)

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin (brand of pentazocine) should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg. *Patients in Labor.* A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: ***Ampuls of 1 ml.,*** **containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. Boxes of 10, 25, and 100.**

Multiple dose vials of 10 ml., **each 1 ml. containing Talwin (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. Boxes of 1.**

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

(1150M)

When moderate to severe anxiety strikes home...

(the agitated geriatric)

His teen-age granddaughter won't invite friends home because of his outbursts.

for moderate to severe anxiety

Mellaril®

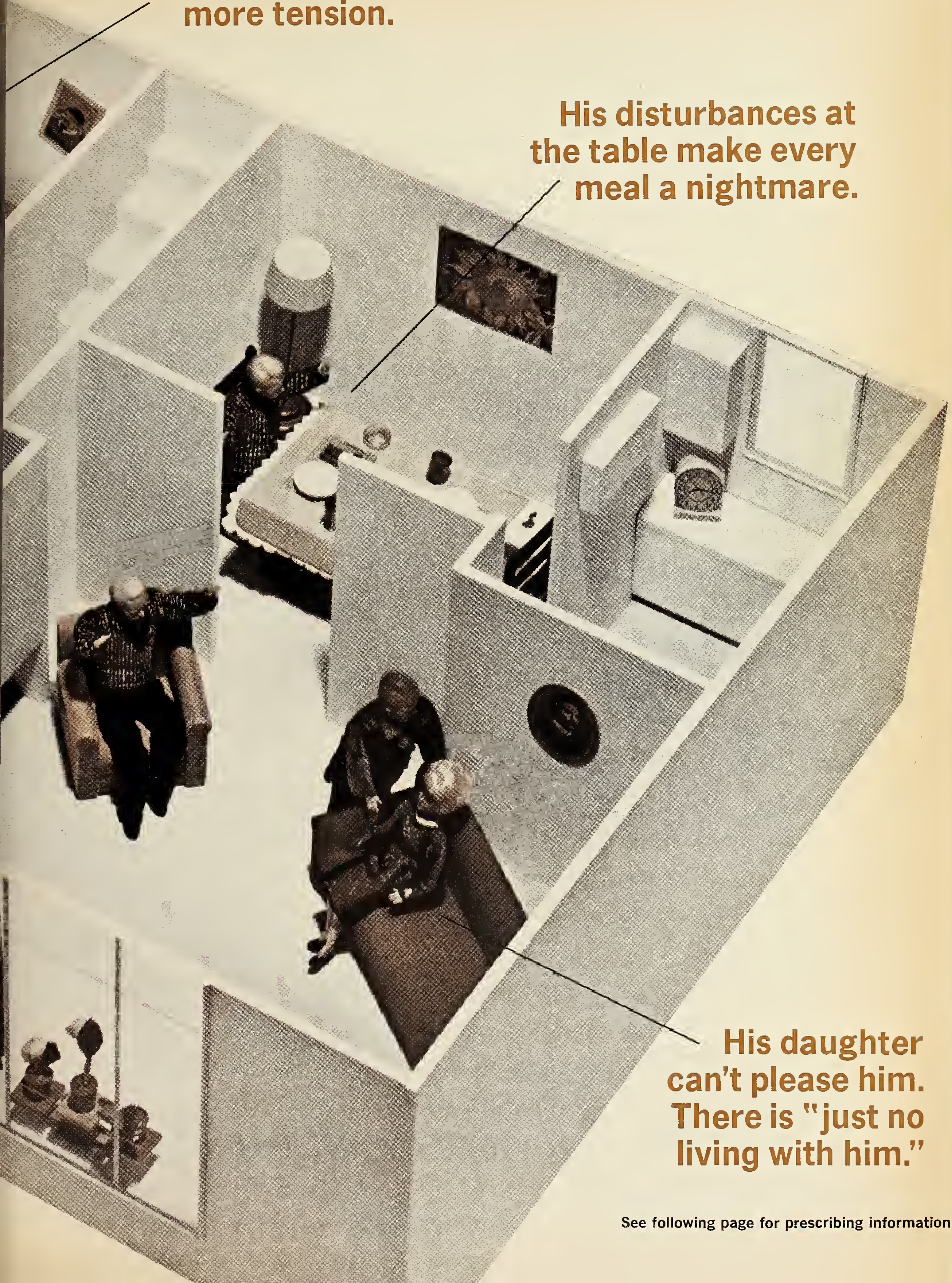
(thioridazine)

25 mg. t.i.d.

SANDOZ

His slovenly room and habits create more tension.

His disturbances at the table make every meal a nightmare.



His daughter can't please him. There is "just no living with him."

See following page for prescribing information.

When moderate to severe anxiety strikes home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe...consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

---

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

This excellent article explaining the Michigan Income Tax Act of 1967 was developed by the Michigan State Chamber of Commerce and appeared recently in one of its bulletins. Permission was granted by the Chamber to Michigan Medicine *to publish the information for MSMS members.*

Explaining the Michigan Income Tax Act of 1967 . . .

The 1967 Income Tax Act establishes an entirely new system of taxation in Michigan by the imposition of an income tax on individuals, corporations and financial institutions. It is the intention of such Act that the income subject to tax be the same as taxable income as defined and applicable to the subject taxpayer in the Internal Revenue Code except as otherwise provided.

Tax Dates:

The Income Tax Act becomes effective October 1, 1967, for everyone except corporations and financial institutions.

The Income Tax Act becomes effective January 1, 1968, for corporations and financial institutions.

Persons subject to Business Activities Tax shall file a return for the full calendar year 1967.

The Business Activities Tax Act shall be repealed December 31, 1967.

Corporations on fiscal years must file a B.A.T. return for the proportionate share of the year through December 31, 1967.

Persons subject to intangibles tax shall file a return for the full calendar year 1967, using $20 as a statutory deduction.

Effective January 1, 1968, and fiscal years ending after June 30, 1968, there shall be a $100 statutory exemption for intangibles taxpayers, with a maximum of $200 deduction for husbands and wives filing joint returns.

Key Definitions:

"Business income." Income from transactions, activities and includes income from tangible and intangible property. (Note: income from intangibles is subject to the Income Tax Act effective October 1, 1967, for individuals and January 1, 1968, for corporations and financial institutions in its entirety.)

"Employer." Has the same meaning as employer as defined in the Internal Revenue Code. Specifically, any person required to withhold for federal income tax purposes shall prima facie be deemed an employer. There shall be a withholding tax on the part of all employers. Forms are being prepared and shall be mailed to all taxpayers at the appropriate time.

"Net profits." Same as Internal Revenue Code, cash or accrual, no deduction of net operating loss carry-over or capital loss carry-over sustained prior to January 1, 1968.

"Resident." An individual domiciled in the State —one-half of the days of a taxable year shall be deemed a resident.

Rates of Tax:

Individual return — the rate of tax is 2.6% of gross income per federal income tax return less the statutory exemption. The income subject to taxation essentially is what you would enter on Line 9 of your federal income tax return. In fact, the Michigan law defines income, with a few exceptions, as it is defined in the Internal Revenue Code. So, it would include interest earned on savings or investments, capital gains from the sale of stock or other items, pensions and the like.

Corporation return — shall be filed on an annual or fiscal year basis in accordance with the filing of their Federal returns. The tax rate is 5.6% of the taxable income as defined in the Act subject to the source and attribution rules contained in this Act.

Financial institutions — are subject to a tax measured by the 7% of taxable income as defined subject to the source and attribution rules contained in this Act. Taxable income in the case of a financial institution means net profits as defined in this Act plus interest or dividends on obligations or securities of any state or public authority other than Michigan.

Exemptions:

$1,200 times number of exemptions listed or qualified for on the Federal return. Returns filed for a portion of the year shall be reduced proportionately — individuals only.

Interest income from obligations of the United

States Government which the State is prohibited from subjecting to a net income tax.

Subtraction of compensation received for servives in the armed forces of the United States included in an adjusted gross income.

In case of husband, subtraction of alimony, separate maintenance payments and principal sums payable in installments to the extent included in the wife's adjusted gross income, per the Internal Revenue Code.

Addition of interest income derived from obligations of states other than Michigan.

Addition or subtraction with respect to the share of estate or trust income, as provided in the Act.

Payments to individuals from Social Security.

Tax Credits:

If the City Income Tax Is:	The Credit Shall be:
Not over $100	20% of City Income Taxes
Over $100, but not over $150	$20.00 plus 15% of excess over $100
Over $150, but not over $200	$27.50 plus 10% of excess over $200
Over $200	$32.50 plus 5% of the excess oxer $200 but total credit shall not exceed $10,000.

If Ad Valorem Property Taxes are:	The Credit Shall be:
Not over $100	20% of the property taxes
Over $100, but not over $150	$20.00 plus 15% of the excess over $100
Over $150, but not over $200	$27.50 plus 10% of excess over $150
Over $200, but not over $10,000	$32.50 plus 5% of the excess over $200
Over $10,000	4% of the property taxes.

Note: Such tax credits only become effective January 1, 1968 and there is no credit for 1967 taxable income.

Records:

Every person liable for any tax imposed under this Act shall keep and maintain accurate records in such form as to make it possible to determine the tax due. Whenever in the judgment of the Department it is necessary, it may require any person, by notice served upon him, to make a return, render under oath such statements or keep such records as the Department deems sufficient to show whether or not the person is liable to tax under the Act. If the taxpayer fails to file a return or to keep and maintain proper, accurate and complete records as prescribed, the Department may assess, upon such information as is available or may come into possession of the Department, the amount of the tax due from the taxpayer. The assessment after notice and hearing as provided in this Act shall be deemed to be prima facie correct for the purpose of this Act and the burden of proof of refuting the assessment shall be upon the taxpayer.

Every person shall keep such records, books and accounts as may be necessary to determine the amount of tax for which it is liable under the provisions of this Act and as the Department may require, for a period of **6 years.** The records, books and accounts shall be opened for examination at any time during regular business hours of the taxpayer by the Department and its agents. Any person who violates any provision of this section is guilty of a misdemeanor and shall be fined not more than $1,000.00 or imprisonment not more than 1 year in the county jail or both.

Withholding:

Beginning **October 1, 1967,** every employer will be required to withhold State of Michigan income tax from salaries, wages or other compensation paid to employees. Each employee, in order for the employer to deem the amount to be withheld, must complete an employee's Michigan Withholding Exemption Certificate — Form MI-W-4. If any employee fails or refuses to file Form MI-W-4, the employer shall withhold tax from the employees total compensation without exemption. The Income Tax Section, Revenue Division, Michigan Department of Treasury, has prepared a sample Michigan withholding tax form which may be ordered from the Department. Form MI-W-4 may also be reproduced, providing the reproduction contains the same information as the forms furnished by the Department. The forms are the same in substance as the federal withholding forms, setting up the number of personal exemptions including an additional one for over 65 and blindness. The personal and dependency exemptions allowable for income tax purposes are also allowable for the Michigan income tax part not including any withholding allowances for itemized deductions. Orders for withholding forms should be addressed on a blank provided to the: Michigan Department of Treasury, Revenue Division, Income Tax Section, 200 Tussing Building, Lansing, Michigan 48922.

Estimated Income Tax Payments:

Every individual, on a calendar year basis required under the Internal Revenue Code to file a return of and pay an estimated tax, if his annual tax can reasonably be expected to exceed the amount withheld and the credits allowed, by more than $100, shall file with the Department, a return of estimated tax under this Act on or before April 15, June 15 and September 15, in his tax year and January 15 in the following year and, subject to the provisions of the Act, shall pay an amount equal to ¼ the taxpayers estimated tax, after first deducting the amount estimated to be withheld under the provisions of the Act.

Enforcement Provisions:

This Act has provisions for criminal penalties as well as procedures to file a lien for delinquent taxes together with serious penalties for fraudulent intention to evade tax running as high as 100% of the deficiency and 1% a month until the tax due is paid, together with criminal penalties.

Specific Questions:

It is recommended that specific questions should be referred to an attorney or an accountant for appropriate opinion and recommendations. General questions will be answered by State Revenue Commission district offices located in Detroit, Pontiac, Grand Rapids, Lansing, Traverse City and Escanaba.

WSU Okays Purchase Of Site for New Medical Library

The purchase of a site at Brush and Canfield streets in Detroit was authorized recently by Wayne State University's Board of Governors for building the Shiffman Medical Library.

Don W. McLean, M.D., Chairman of Wayne County Medical Society's Library and Museum Committee, reports that plans are underway to have a William Stapleton Room in the library to honor Doctor Stapleton, one of Detroit's most beloved physicians who still is practicing medicine after 50 years of service.

The Shiffman Medical Library, to be started this year, will be near the Detroit Medical Center and will serve Wayne State University Medical School and the medical profession in Detroit.

MAP Television Program Features More Doctors

The MAP television program, over WJIM-TV, Channel 6 in Lansing, often spotlights physicians.

Discussing "Formula for Arthritics" recently were James J. Lightbody, M.D., of Detroit, Alfred B. Swanson, M.D., of Grand Rapids, and Edwin M. Smith, M.D., of Ann Arbor.

David C. Asselin, M.D., chief of Psychiatry, St. Lawrence Hospital, Lansing, and psychiatric consultant, Boy's Training School, discussed "Formula for Preventing Crime," on another recent program.

MSMS HISTORY MERITS TRIBUTES FOR AUTHOR

Sincere, deep appreciation to William J. Stapleton, Jr., M.D., Detroit, MSMS Historian, is voiced by many writers in the glowing letters of thanks to MSMS for copies of *A Century of Service in Medicine*. As a public relations project, the volume is being distributed to professional associations, museums, libraries, colleges and universities, newspapers, and others.

A Century of Service in Medicine was written by William J. Stapleton, Jr., M.D., Detroit, the MSMS Historian, as a part of the MSMS Centennial Celebration.

Physicians may still obtain a copy of the book for $2.00, the cost of printing the 56-page, hardbound edition.

Excerpts from some of the letters follow:

"Your masterpiece *A Century of Service in Medicine* was received a few days ago. It is obvious that it was written with great knowledge and perspicacity. It was a real treat to read it and reflect on bygone days."

Clarence I. Owen, M.D.
MSMS Past President
Jacksonville, Florida

"Our sincerest thanks for a copy of *A Century of Service in Medicine* which you recently sent us.

"Our sincerest congratulations to the Michigan State Medical Society on this publication, and in particular to Doctor Stapleton who, I am certain, spent many hours gathering the information and putting it into publication form."

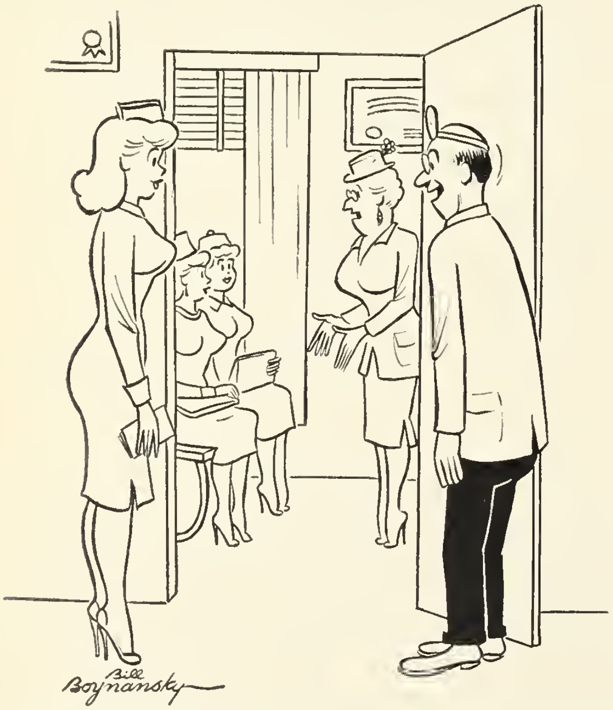
J. E. Gajewski, M.D.
Parke, Davis & Company
Detroit

MEDICARE—BENEFITS AND GAPS; SOCIAL SECURITY—YOUR RIGHTS:

Written by Sidney Margolius. What you should know about Medicare and Social Security to be eligible for financial protection against "the costs of two of the inevitable hazards of life: old age and sickness." Includes an explanation of the benefits and how to claim them and suggests what to look for in supplementary insurance plans. Copies available from: Public Affairs Committee, Inc., 381 Park Avenue South, New York, New York 10016. $0.25 each, lower in quantity.

A STUDY OF THE USE OF HOMEMAKER SERVICES WITH THE MENTALLY ILL:

Written by four students at the University of Connecticut School of Social Work as partial fulfillment of the requirements of a master's degree in social work. The study aims to determine the value of homemaker service to the mentally ill, the subjects being thirty mentally-ill women, all married, having two or more children, and recipients of homemaker service from the Family Service Society of Hartford, Connecticut. Copies available on request from: National Council for Homemaker Services Lending Library, 1790 Broadway, New York, New York 10019.

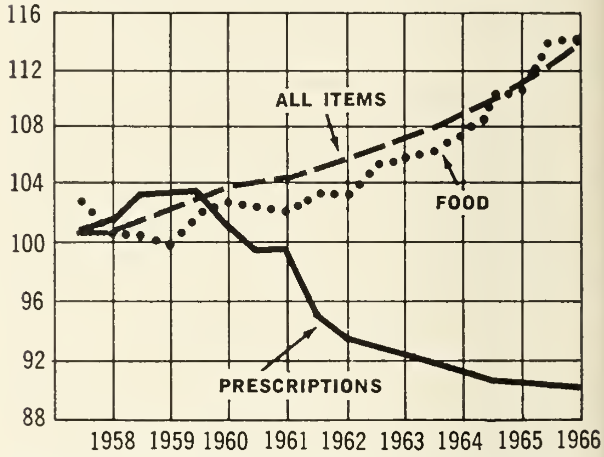


"Better call in Mrs. Wood next before she has a chance to give them all the wrong advice!"

JOIN IN VOLUNTARY EFFORT

The Ingham County Medical Society and the Michigan State University College of Human Medicine are among the groups co-sponsoring the new Lansing Area Health Facility Planning Council. East Lansing City Manager, John M. Patriarche, was elected the first council president.

RETAIL PRESCRIPTION DRUG PRICES DOWN



Consumers are paying consistently lower prices for prescription drugs, while the cost of living generally continues to rise, U. S. government figures show. A comparison of retail drug prices with the prices of food and with all commodities for the past seven years shows that drug prices began to drop in 1960 and have continued downward ever since, reaching new lows in 1966. Other prices have followed an upward trend over the same period.

(Source: U. S. Bureau of Labor Statistics, Consumer Price Index. Base, 1957-59=100.)

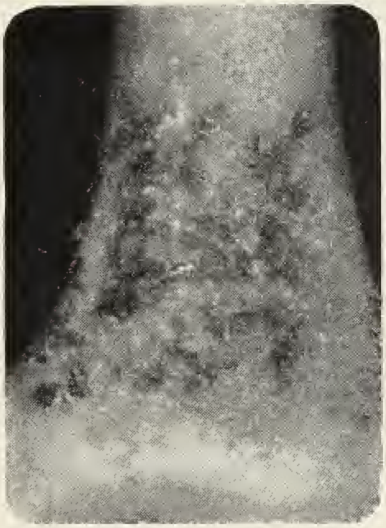
Proud Moments!

"The Afflicted Child Act was passed in the closing hours of the Legislature and was signed by the Governor on May 29, 1935. The law allowed a Probate Judge to send those afflicted children who come under this law to local hospitals and allows compensation to the attending physician or doctor. The cost of the medical and hospital care was assumed by the state and paid through the hospital. The operation of this act was placed under the control of the Crippled Children Commission."

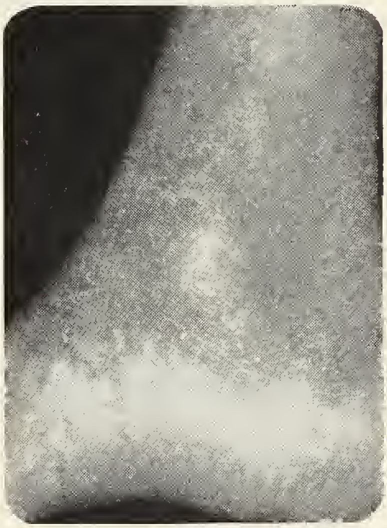
That quotation about a highlight in MSMS history is taken from *"A Century of Service in Medicine—A History of the Michigan State Medical Society"* by Wm. J. Stapleton, Jr., M.D., Detroit, the MSMS Historian.

Copies of the handsome book may be obtained from the Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823, for $2.00 each.

Eczema of many years... controlled in two weeks



Before treatment



After treatment—
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and *Dosage:* Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and *Side Effects:* Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
Also available in foam form.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

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Behind-the-classroom instruction is possible in smaller communities, thanks to a special bus equipped with six Drivotrainer cars and facilities for showing 21 training films. Many urban schools have permanent Drivotrainer installations.

Study Would Raise Driver-License Age

"The minimum driver licensing age should be raised from 16 to 17."

That is one of the many recommendations of interest to physicians and Michigan citizens contained in the Michigan State University Highway Traffic Safety Center's recent Study of Michigan's Driver Education Program."

Hand-in-hand with raising the minimum age, the Center contends that students should be at least 16 before they can enroll in a driver education course. MSU experts argue that students 17 generally are more mature than those 16.

Another recommendation says, "The Michigan Department of Education should deny students having unsafe physical deficiencies the practice-driving portion of driver education programs." The MSU study points out that no rules exist, but are desired by some teachers of driving, to implement the above recommendation. The American Medical Association, cited in the Center's report does not favor medical examinations as a requirement for obtaining a driver's license.

Scientific data, the AMA states, do not show a correlation between diseased drivers and high accident rates. The Center's response is that visual, mental or muscular disorders could very likely impair driving ability. The MSU Report designates the State Department of Education as the authority to establish proper regulations.

THESE RECOMMENDATIONS are among 50 in the Report on driver education. Governor

Romney requested the study in a legislative message in 1965.

Driver education started in Michigan in 1956. But since then, the increased complexity of driving, a doubling of the number of driver-education students, the slow use of new methods and techniques, inadequate funding, and the lack of respect for training courses in the high school curriculum are begging improvements in the program, reports the Center. Its recommendations focus on the program's administration and organization, teacher preparation, student training, facilities, financing, parental support, and recommendations for all new drivers.

Directors of the study were Robert O. Nolan, Associate Professor in driver education, and Robert E. Gustafson, Assistant Professor in driver education.

The study was based on questionnaires from 1,403 driver-education teachers in Michigan, interviews with instructors in 56 public school districts, and 935 interviews with the public.

The most notable result of the study was an increase from $25 to $30 in the state reimbursement to school districts giving driver training. The enabling legislation which increased driver license fees was enacted in the end of the 1966 session, after the Center released a report on the legislation needed to improve driver education.

ALSO UPON THE Center's recommendation, the Legislature acted to provide $100,000 annually to the Department of Education for state administration of the driver-education program. This amount provides supervision, assistance, coordination, and consistency for high school driver-training programs. The Center is on record that driver training be given only by schools offering high school diplomas and a training program approved by the state education department.

The MSU Report states that 98 percent of those it interviewed believed driver education should be taught in public schools. Some of the reasons given were: Driver education is a part of the youngster's general education and public schools can best provide the proper environment, personnel, facilities, and availability for the program.

Another recommendation would provide adequate driving experience before a license is issued. If implemented by the Legislature and Department of Education, students would be able to drive with parents or a legal guardian during the course, with the approval of their teacher and a licensing authority. Also, the student would be required after the course to drive with parents or guardian for not less than 90 days or until age 17, whichever comes later.

THE REPORT FURTHER suggests legislation requiring all new drivers over age 18 to take a driver-education course before getting a license. Nine out of 10 interviewees favor this recommendation, according to a survey, "Public Opinion in Michigan on Traffic Accident Prevention," conducted by the MSU Department of Communication for the Center.

Some of the reasons cited for approval of this requirement are that driving demands more skill today, the course is available to all ages, and the competence of non-professional trained instructors is questionable.

A related recommendation suggests insuring the availability of the driver-education course to drop-outs. The Center found that a few of the 57 school districts investigated do not offer the program to drop-outs.

Most of the other recommendations deal with quality improvement of driver-training courses and their teachers. The most significant recommendation urges that driver-education instructors be required to have a teaching minor in driver education, a secondary teaching certificate, and a good driving record themselves.

At MSU two courses in driver education will be required for instructors by this July. As of 1968, three courses will be the minimum, according to Leslie Silvernale, Assistant Director of the Center and Director of the driver-education program for the Center. In 1952 he established the first full-time driver-training teacher preparation program at MSU.

Mr. Silvernale suggests that 10 courses be required for a minor. Course subjects, he said, should include traffic engineering, auto mechanics, alcohol education, local safety organization, and audio-visual aids.

Since publication of the study last December, reports have been given to the legislators, safety organizations, and driver-education teachers. Radio and television stations have been provided announcements and prepared editorials.

Seeking an even wider audience is in line with the Center's goals. The study stresses that all elements of a community must work to improve all facets of the driver-education program.

Physicians interested in details of the driver education study are invited to write to the MSU Highway Trawc Safety Center, Continuing Education Service, MSU, for a copy of a booklet, "You and the Action Team for Quality Driver Education in Michigan."

removes the mental blur

that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL . . . . 16 mg.
(Warning: may be habit forming)
BENSULFOID ® (See P D R) . . . . . .65 mg.
Precaution: same as 16 mg. of phenobarbital

SUSTAINED SEDATION
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Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

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Solfoton *(yellow, uncoated tablets "P")*
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Solfoton Capsules *(yellow and brown)*
100s, 500s, 1000s
Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

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Manufacturers of ethical pharmaceuticals since 1856

HEALTH GUARDIAN

FROM AMARILLO GLOBE-TIMES

"A lot of people seem to believe that before Medicare we lived by the law of the jungle. A little lesson in history will help place recent Congressional innovations in more accurate perspective. In 1847, formalized medical education was practically nonexistent. Men actually bought medical degrees for a little cash. Many who hung up shingles had no medical training. Medical quackery was rampant. There was no recognized code of ethics for physicians.

"In 1847, 250 physicians met in the Academy of Natural Sciences in Philadelphia and founded the American Medical Association. Thus, began a crusade for better medical care. Today, the Association's membership includes more than 206,000 physicians.

"The AMA carries on a continuing program to promote the art and science of medicine and the betterment of public health. Its activities are so widespread they defy adequate description in a limited space. It sponsors more than 1,000 meetings a year. Its clinical conventions are the most important post-graduate medical study sessions in the world. These meetings encompass some 400 scientific lectures; between 350 and 400 scientific exhibits, 300 to 400 industrial exhibits illustrating new drugs, equipment and books; outstanding medical motion pictures, and special color television presentations.

"The AMA records department keeps complete records on all licensed physicians, beginning from the time a student enters medical school. Most of the laws on the statute books today having to do with health and medicine are based on proposals and recommendations of the medical profession through its spokesman, the AMA. The Association has been described as the guardian of the nation's health — and it most assuredly is."

Health Care Demands Rise

"Medical services are expected to grow rapidly as the result of recent expansions of Social Security programs. The Medicare program initiated in 1966 is assumed to be the first of a series of expansions of programs to provide for improved medical services for the population. Therefore, in addition to serving a growing population with expanding incomes, the medical-service industry will offer improved and more expensive services. In 1960, 11.9 percent of the population of Michigan was age 60 and over. In 1980, 12.5 percent will be over 60 years of age and the actual number of persons in this age classification will be increased to 351,000."

—Michigan Manpower Study, 1966
Page 56

fall 1967

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M. D., Director of Medicine.

this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air might do this. A siege of smog in Denver, the "mile high city," in December 1965 was accompanied by respiratory infection that doubled normal absentee rates in schools, factories and city government.[10]

While air pollution is only one factor, it has become important in the causes of most of the afflictions of the respiratory tract. This has been shown not only by the Denver occurrence, but also by detailed study[2] of respiratory illness in a small group of 313 men

from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

For nature's hazards:
nasal congestion
due to seasonal
allergies and
summer colds

Triaminic® *syrup*

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
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For nasal congestion regardless of cause, you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of antipollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

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How can he be a sport with a runny nose?

For summer allergies, summer colds, or nasal congestion due to almost any cause, you prescribe quick r-e-l-i-e-f with Triaminic. It's ideal for summer allergies:

1. Acts in 15-30 minutes due to decongestant.
2. Follows up with balanced dual antihistamines.
3. Up to 24-hour 'round the clock relief when dosed one tablet at morning, midafternoon and evening.

Summer time is sport time and who can be a sport with a runny nose?

provide patient comfort
Triaminic® relieves summer allergies

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
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Side effects: Occasional drowsiness, blurred vision, cardiac palpitation, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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CIVIC AUDITORIUM

MICHIGAN STATE MEDICAL SOCIETY

102nd Annual Session

GRAND RAPIDS CIVIC AUDITORIUM

SEPTEMBER 27-28-29

MICHIGAN MEDICINE

DEADLINE FOR THIS BREAKING NEWS WAS AUGUST 24, 1967

Personal Invitation To Annual Session:

A chief concern in planning the MSMS Annual Session this year in Grand Rapids, September 27-29, has been to insure that each Michigan physician will have an opportunity to get scientific answers to some of the questions which confront him in his daily practice of medicine.

All doctors have many demands on our time, both as physicians and as citizens of our community. At the same time we are aware of the explosion of medical knowledge and the absolute necessity of keeping up-to-date if we are going to be creative physicians.

WITH THIS IN mind, as President of the Michigan State Medical Society, I want to personally invite you to the Annual Session in Grand Rapids because I am convinced that the time you spend there will make your medical practice more effective and rewarding and will, in the long run, save you time.

This year we have initiated "Curbstone Conferences." These discussions will help you unsnarl the complexities of Medicare and Medicaid and help you in office efficiency. They will be an opportunity to compare notes with other physicians and talk with the leaders of the Michigan agencies which operate Medicare and Medicaid. Discussions will be held on both Wednesday and Friday mornings, September 27 and 29, from 8:45 until noon.

Another feature this year is "Luncheon with the Speakers." Three scientific presentations by medical experts from around the nation will be going on simultaneously during any hour of the Annual Session. Thirty-two subjects will be covered. While this offers you maximum opportunity for selection, you may want to discuss something with a speaker whose talk you could not attend. Or you may want to go more deeply into a talk which you did hear. Both of these opportunities will be yours because scientific speakers will sit at assigned places for lunch. You will be free to sit with any of the speakers and discuss anything which you want cleared up.

BLOCKS OF THE program will be devoted to Section meetings as well as scientific presentations. These talks are designed to be helpful for hospital practice and office procedures.

Convenience is another feature this year. All educational exhibits will be on the first floor where the scientific meetings will be held. No more trudging from first floor to basement between scientific presentations.

I could multiply reasons urging you to attend the Annual Session. Space has permitted me to touch upon only a few.

Hoping to see you in Grand Rapids at the Pantlind Hotel in September, I am

Sincerely yours,

C. Allen Payne MD

C. Allen Payne, President
Michigan State Medical Society

Editorial: Thanks and Good Luck

It is with sincere regret that we learn of the recent resignation of Albert E. Heustis, M.D., as Director of the Michigan Department of Health.

The outstanding leadership of this scientist and administrator is very largely responsible for the development of a superb governmental agency devoted to the protection of the health of the people of Michigan. Owing to Doctor Heustis' progressive attitude in public health, many new projects and innovations have been pioneered and subsequently proven to be of considerable worth.

It has been the good fortune and pleasure of the officers, members of The Council, and many committees of MSMS to work very closely with Doctor Heustis and the members of his staff during the 19 years of his tenure. An attitude of mutual respect has always been maintained throughout the numerous discussions and conferences that were necessary to resolve the many problems common to the realization of our goal of better preventive medicine and health care for all of our citizens.

We note with pleasure that Doctor Heustis' leadership will not be lost to Michigan. It will be our further pleasure to work cooperatively with the Michigan Association of Regional Medical Programs of which he will be director.

The Michigan State Medical Society is a member organization of this agency and believes that it represents an important challenge to improve further physicians' education and to make available the best that medicine can offer. We feel sure that MARMP will develop into one of the best of the heart, cancer, stroke programs throughout the United States.

On behalf of MSMS, may I extend to Doctor Heustis our heartfelt thanks for a splendid job very well done and also extend our very best wishes for complete success with this new challenge.

C. Allen Payne, M.D.
MSMS President

MSMS Leaders Testify on Three Bills

Teams of Michigan physicians have testified on three different bills before the Michigan legislature.

One group, led by Louis Hayes, M.D., Gaylord, and Robert Stow, M.D., Lansing, presented several hours of testimony on Senate Bill 227, dealing with chiropractors. The meeting was August 22, before the House State Affairs Committee in the Capitol.

On August 25, John Rodger, M.D., Bellaire, testified on ambulance service in Michigan before a special legislative committee in Petoskey. This same committee is later to meet with other physicians in Ann Arbor and Lansing.

On August 28 Otto K. Engleke, M.D., Legal Affairs Committee Chairman, Richard Weber, MSMS Associate Legal Counsel, and other physicians testified before the State Senate Judiciary Committee in the Appellate Court Chambers in Lansing about amending Michigan's therepeutic abortion law.

Harris to Present MSMS Resolution At U-M Reunion

During the 1966 House of Delegates meeting it was resolved tha MSMS offer "highest commendation and appreciation to the University of Michigan Medical Schoo and the University of Michigar for valued service over the year to the people of the world and tc the profession of medicine."

Bradley M. Harris, M.D., Ypsilanti, President-Elect of MSMS will present the citation at the annual business meeting luncheon o the Medical Center Alumni o October 6.

Further details about the Alumni Reunion appear in the Augus and September issues of *Michigar Medicine*.

Doctors to Appear At PTA Workshops On Smoking-Health

The Michigan Council on Smoking and Health will cooperat with the Michigan Congress o Parents and Teachers to sponso a series of workshops across th state on Smoking and Health thi fall.

Physicians will appear in th series of workshops during October and November to speak o the dangers of smoking. The project is regarded as one of the mos ambitious and important undertaken by any group of parents.

Michigan PTA leaders have ambitious goals — to reach 310,00 members and to inform and motivate them to help prevent thei children from starting the smoking habit.

C. Allen Payne, M.D., left, Grand Rapids, will complete his year as MSMS president at the Grand Rapids session, and Bradley M. Harris, Ypsilanti, now president-elect, will be installed formally as the 1967-1968 president during the MSMS Dinner Dance Program, Wednesday, September 27.

News in Brief:

The American Association of Medical Assistants will hold its 1th Annual Convention, October 1-15, at the International Hotel n Los Angeles. Details may be obtained from the California Medical Assistants Association, 693 Sutter Street, San Francisco 94102.

* * *

"Blueprint for the Future" is he theme of the Mississippi Valey Conference on Tuberculosis in Grand Rapids, October 4-6. Among the many fine speakers is David Greeley, M.D., of Chicago, Illinois, who will speak on "Probems of Metropolitan Areas in Comprehensive Health Planning," on October 5, at 10:15 a.m.

* * *

Bronson Methodist Hospital's Eighth Annual Clinical Conference will be held on Wednesday, October 18, in the Bronson School of Nursing's Trusedale Hall, Kalamazoo. The presiding officer at the one-day conference entitled "Hematology: Recent Advances (other than Leukemia and Lymphoma)" is John D. Pool, M.D.,

Guest panelists will include Carl V. Moore, M.D., Washington University, St. Louis, Mo.; Alvin Zipursky, M.D., McMaster University, Hamilton, Ontario; Tommy Evans, M.D., Wayne State University, Detroit; and Henry Gans, M.D., University of Minnesota.

All physicians are invited to preregister for the conference. There is no fee.

* * *

The Seventh Annual Thyroid Workshop of the Wayne State University College of Medicine will be held Wednesday, January 24, 1968. The principal speaker will be John Stanbury, M.D., of the Massachusetts General Hospital, Boston, Massachusetts.

Inquiries may be addressed to Nelson M. Taylor, M.D., 722 Notre Dame, Grosse Pointe, Michigan 48230.

RULES MD NEED NOT BE PRESENT WHEN BLOOD SAMPLE TAKEN

A doctor need not be present when a blood sample is withdrawn from a drunk-driver suspect Attorney General Frank J. Kelley ruled recently.

The licensed nurse or laboratory technician taking the sample must be acting under the "direction" of a licensed physician, however, Mr. Kelley said.

Prosecutor John H. Butts of Cheboygan County had asked Mr. Kelley whether Act 104 of 1964 requires a doctor to be present when the sample is taken.

Mr. Kelley said that was a requirement of an earlier law (A 148, PA 1960), which contained the phrase "under the supervision of a licensed physician." The 1964 act, however, substituted the word "direction" for "supervision" in the law.

Substitution of the term makes it clear the Legislature intended only that the nurse or technician need be acting pursuant to the "authoritative instruction" of a doctor and at the request of a police officer, Kelley said.

"The word 'direction' does not imply superintendence or supervision of the work done," said Mr. Kelley, citing *Klutz* v. *Citron* (148 NYS 2d 367; S.Ct. App.Div., 2d Dept., 1957 and *Kellyville Coal Co.* v. *Bruzas* (79 NE 309 Ill.; 906).

The Attorney General's office said the opinion does not take into account the language regarding the taking of blood samples in the new implied consent law.

You're Invited to Gala Dinner Dance Wednesday, Sept. 27

The 1967 Annual MSMS State Society Dinner Dance, Wednesday, September 27, will take on a "Celebrity Night" atmosphere.

All MSMS members are invited to help focus attention on the honored guests and special celebrities.

THE DINNER DANCE will be the social highlight of the MSMS-Week-in-Grand-Rapids. There will be excellent food, warm fellowship, enjoyable dance music, and special spotlight festivities.

B. M. Harris, M.D., Ypsilanti, will be installed as the 102nd MSMS President to succeed C. Allen Payne, M.D., Grand Rapids.

The MSMS members who are serving as presidents of national medical organizations will be presented MSMS awards as part of the program.

Presidents of the MSMS component medical societies also will be in the spotlight in recognition of the important roles they play.

The presidents of the state Woman's Auxiliary and the state Medical Assistants Society will step into the spotlight too.

THE PLANNING COMMITTEE for the gala Dinner Dance points out that the event again will be black tie—optional with the ladies in their prettiest evening gowns.

Interested MSMS members are urged to use the reservation blank to assure themselves of a share in the celebrity night.

MAIL TO MSMS, P.O. BOX 152, EAST LANSING

RESERVATION ORDER MSMS DINNER DANCE, SEPT. 27

Please reserve ____ tickets for the Annual MSMS Dinner Dance at 7 p.m., September 27 at the Civic Auditorium. Attached is my check for tickets, $10.00 per person.

Name ______________________

Address ______________________

City ______________________

Who Will Receive Top Honors?

The time is drawing near for the announcemer of the recipients of the Michigan State Medic Society's highest awards.

Scheduled to be presented Tuesday mornin September 26, at 11:30, during the MSMS Annu Session in Grand Rapids, Speaker of the House c Delegates James J. Lightbody, M.D., Detroit, wi make the presentations.

EACH YEAR ONE physician is named "Micl igan's Outstanding Physician." Begun in 1965, th recipient of this annual award is chosen by a sp cial MSMS House of Delegates committee fro candidates nominated by the county medical s cieties. G. H. Rigterink, M.D., Kalamazoo, i chairman of this year's committee.

The first "Outstanding Physician" was Frankli L. Troost, M.D., Holt. The 1966 award was pr sented posthumously to William A. Hyland, M.D Grand Rapids.

A VERY FEW PHYSICIANS each year ar awarded coveted "Certificates of Commendation. Also chosen by a special House of Delegates com mittee, led this year by Alfred H. Whittaker, M.D Detroit, the Certificates were first given in 196 In the past this award has been given to the fo lowing:

From Detroit: Charles S. Kennedy, M.D.; Rob ert L. Novy, M.D.; Charles J. Jentgen, M.D. Remus J. Robinson, M.D.; Traian Leucutia, M.D. Ralph H. Pino, M.D.

From Ann Arbor: Jerome W. Conn, M.D.; Joh M. Sheldon, M.D.; Norman F. Miller, M.D.; Fre J. Hodges, M.D.; Arthur C. Curtis, M.D.; Mar Marshall, M.D.; Harry A. Towsley, M.D.

From Lansing: G. D. Cummings, M.D.; Goldi B. Corneliuson, M.D.

From Grand Rapids: Alfred B. Swanson, M.D

From Bloomfield Hills: Forest D. Dodrill, M.D

From Milan: John S. DeTar, M.D.

From Saginaw: Robert M. Heavenrich, M.D.

From Ypsilanti: Orus R. Yoder, M.D.

From Kalamazoo: E. Gifford Upjohn, M.D. Homer H. Stryker, M.D.

From Mt. Pleasant: Lionel L. Davis, M.D.

From Coldwater: H. J. Meier, M.D.

Also honored at the Annual Session will be phy sicians who have practiced medicine for 50 years They will be awarded 50-Year Pins for their half century of service.

Legislative Committee Holds Hearings On Emergency Medical Transportation

A special House Committee on Ambulance Servce in Michigan has been conducting state-wide public hearings since the latter part of July. Hearngs have already been held in Flint and the Upper Peninsula, and three hearings are still to be conducted. The three remaining hearings are set n Ann Arbor for September 15 for the Southeastern Michigan area, October 13 for the Petoskey area, and October 20 in Lansing for the final hearing.

The special Committee, chaired by Representative Robert W. Davis, St. Ignace, also includes Representatives Callahan, Mt. Morris, Jowett, Port Huron; Smit, Ann Arbor; and Kehres, Monroe.

In a statement issued to MSMS, Representative Davis cited three basic reasons for this study committee:

1. The shortage of ambulance service. Present ambulance service companies, which for the most part are operated by funeral homes, are leaving the ambulance business owing to their inability to get proper personnel and to collect bills, regulations under Medicare, financial liability costs, and the increase in the minimum hourly wage.
2. The medical profession is increasingly concerned with the necessity of minimum standards for attendants-drivers and ambulance equipment.
3. The source and method of financing ambulance service in Michigan needs study. Hearings will determine the necessity of and the feasibility for participation of funding by city, county, and township units of government to assist and subsidize ambulance service companies.

Invited to testify before the Committee are ambulance companies, chairmen of boards of supervisors, mayors, hospital administrators, medical doctors, osteopaths, state police, sheriffs, funeral directors, and technical resource personnel as well as legislators from the areas in which these hearngs will be held.

The MSMS Committee on Highway Accident Prevention and The Council have asked physicians "To take an active part in such training and consultation" and have said "Doctors should be active n implementing satisfactory first-aid courses and should encourage their respective communities to offer such courses." The MSMS Committee has been deeply concerned about the initiation of House of Representative Resolution 65 which established the special Committee for an "in-depth study of the emergency medical transportation system in Michigan and hopefully will lead to legislation which would require minimum standards for ambulance service and insure fair compensation to those who provide such services."

P. W. Gikas, M.D., Chairman of the MSMS Committee on Highway Accident Prevention feels strongly that "the grade and level of emergency service must be updated."

The Council and the MSMS Committee urge every physician to support and cooperate with the Study Commission in an effort to find a reasonable, sound, and equitable bill to be introduced in the House early next year.

SEEK TO BAN HOSPITAL SALE OF CIGARETTES

The newest step by MSMS to alert the public to the dangers of cigarette smoking is a recommendation by the Committee on Respiratory Diseases that all Michigan hospitals discontinue the sale of cigarettes within the hospital.

The importance of the recommendation, which has been approved by the MSMS Council, is highlighted by Richard R. Rasmussen, M.D., chairman of the committee: "Hospitals are places where we foster the recovery of health, and ironically we permit the sale of a health hazard within the hospital itself."

Another indication of the MSMS position on cigarette smoking as a health hazard is the policy of not accepting cigarette ads in the journal. Also MSMS is a participating member of the Michigan Council on Smoking and Health.

viewpoints

The Decent Society

BY EDWARD J. TALLANT, M.D.

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FROM DETROIT MEDICAL NEWS

Our government was founded on certain basic philosophic concepts. All rights and powers are granted to the individual by God. In order to form an orderly functioning society each individual, by actual or implied consent, surrenders to society as a whole those of his rights which the governing body must have in order to achieve its function, namely an organized society which protects his rights. The administrators of these delegated rights are the elected representatives of the people. Along with the authority which is given to the elected representatives and their administrative assistants goes the responsibility of the proper safeguarding of the basic inherent rights of the individual.

Any government which cannot or will not recognize and protect the rights of every individual has lost its right to govern; it may, as so often occurs, continue to govern by might, not right.

We have been hearing so much about the Great Society that there is a tendency to forget, particularly on the part of appointed governmental agents, that the greatest society is one which respects and protects the rights and privileges of all individuals equally. This function of government may, and frequently does, require the judicious and at times forceful use of the police powers of the government.

Our founding fathers recognized the right of majority rule but at the same time built into our social structure safeguards to protect the rights of the minority against what has been aptly termed the dictatorship of the majority. It was for that reason that certain functions of Congress require a two-thirds vote and other functions require a three-fourths vote for approval. It was also for this reason that majority rule was tempered by building into our governmental system methods of election of representatives in which a one-man, one-vote principle was deliberately disregarded. This latter is best exemplified by the election of the members of the House of Representatives on a population basis and the members of the Senate on a basis of two from each state.

Today there is so much emphasis on the Great Society with its ancillary emphasis on "social reconstruction" that the basic rights of too many of our citizens are being ignored or at best not respected.

Regardless of race, sex, religious beliefs or economic status no one has the right to walk over the rights of others. Riots in which cars are burned, looting becomes rampant, arson produces millions of dollars worth of damage, as well as the actual bodily harm inflicted on innocent citizens, is not to be tolerated. All citizens must have equal rights and equal protection under the law. No group can be permitted to trample upon the rights of others. Governmental agencies, particularly the police and military arms, must use *all* forces available to them to protect the rights of all. Rights and decency must prevail.

Let us first produce a Decent Society and it will follow that we will have a Great Society.

Seat Belts And Money in the Bank

A recent study, directed by Professor James N. Morgan and the University of Michigan Highway Survey Research Center shows that "The better educated you are, the more likely you are to stay alive on the highway." The study also disclosed that in the United States population at large, only one person in four wore seat belts at least some of the time while those persons with education beyond a bachelor's degree showed that three out of four persons used seat belts at least some of the time.

Another study made by U of M Professors Donald Huelke and Paul Gikas, M.D., Chairman of the MSMS Committee on Highway Accident Prevention, showed that 40% of the persons killed in highway accidents would have lived had they worn restraints properly.

The HSRI has 90 persons working on more than 40 auto safety research projects to further study the effectiveness of restraint and other passenger protection systems. These findings are reported in a U of M book called *Productive Americans: A Study of How Individuals Contribute to Economic Progress* and tended to relate the use of seat belts with those having some savings in a bank; those who have had polio shots; those who use other new products appearing on the market; those who express unqualified approval of the addition of fluoride to water, and people who approve of the idea of trying to land a man on the moon.

All this seems to indicate that the use of seat belts implies a faith in modern science and credibility in research reports.

Your MSMS Committee on Highway Accident Prevention has been unceasing in urging every physician to use proper restraining apparatus when driving.

B.L.M.

Speaking of Malpractice Insurance....

Have you checked the advantages of insuring with Shelby Mutual Insurance Company? This plan is sponsored by Michigan Association of the Professions and is available to members of the Michigan State Medical Society.

Here is why it might be beneficial for you to investigate

* Very Broad Coverage

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100/300,000	$97.00	$122.00	$234.00	$349.00	$27.00

(Premises Coverage Required with Professional Liability)

Class 1 — PHYSICIANS — No surgery.

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Class 3 — SURGEONS — General practitioners who perform major surgery or assist in major surgery on other than own patients.

Class 4 — SURGEONS — Specialists.

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Sesquicentennial to Add Color October 5-7 To U-M Medical Alumni Reunion

Several hundred alumni of The University of Michigan Medical Center will return to the campus October 5-7 for the annual Alumni Society Conference.

Special programs during this Sesquicentennial Year will highlight the three days of fellowship, fun, and clinical conferences.

Sesquicentennial Awards are to be presented at the annual banquet Friday evening, October 6.

Alumni will hear addresses by internationally renowned physicians, scientists, and statesmen during the U-M Major Sesquicentennial Celebration, "Voices of Civilization."

Dean William N. Hubbard, Jr., M.D., will give the returning alumni an overview of the transformation that has taken place at the Medical Center. He will speak Friday on "Medical Center Growth — Today and Tomorrow."

The sixth annual Carl Badgley Lecture will be given by H. Relton McCarrol, M.D., Professor of Orthopedic Surgery at Washington University, St. Louis, Missouri.

On October 6, conferees will have a wide choice of clinical conferences and open-house events programmed by the Medical Center departments.

Class members graduating in the years ending in twos and sevens will have a special social reunion on Thursday evening. Friday's events will include induction of the 1917 classes into the Emeritus Club and annual business meeting. Saturday's highlights will be the reunion picnic and the Michigan vs Navy football game.

The Medical Center conference is open to all former students of the U-M Medical School, School of Nursing, and University Hospital residents, interns, and faculty.

Will Direct Center For Forensic Psychiatry

William H. Anderson, M.D., Director of the Michigan Department of Mental Health, has appointed Ames Robey, M.D., to be Director of the Department's new Center for Forensic Psychiatry.

The Center's temporary offices are at Ypsilanti State Hospital.

The Center for Forensic Psychiatry was authorized by the Legislature last year and its purpose is to diagnose and evaluate patients committed to the department or criminal courts; to report findings and recommendations to the department and courts; and to conduct research on the inter-relationship of mental disability and criminal law. After such evaluation is made by the Center, the patients will be returned to the courts for trial or assigned to the various regional State hospitals for treatment. Doctor Anderson said "This new diagnostic center will aid our department and the courts to more rapidly and effectively dispose of criminal cases in which mental illness of the accused is purported to be a factor."

Doctor Robey, certified in psychiatry by the American Board of Psychiatry and Neurology, formerly served as medical director of the Massachusetts Correctional Institution at Bridgewater State Hospital.

Reports End of Bias In Detroit Hospitals

"Discrimination against Negro physicians and patients in Detroit hospitals has practically disappeared," according to J. S. Williams, M.D., President of the Detroit Medical Society.

Speaking at the tenth annual clinic day of the Society, held recently in Detroit, Doctor Williams remarked to nearly 100 doctors that "In the past we have made charges that hospitals in this city discriminated against doctors and patients because of their race. Today, we have no such charges because Negroes have free access to hospital beds and Negro doctors can become staff members of all of our hospitals."

"If there is discrimination, then it is much too subtle to detect," Doctor Williams said. "But as far as we know we don't have a complaint against any hospital."

"This will be very helpful to us," he added, "in trying to encourage young Negroes to become physicians. We can honestly state now that there are more opportunities than there are physicians to fill them."

BIRTH RATE DECLINES

In 1966 the state birth rate continued its downward trend with 290 fewer births reported than in 1965. Figures released by the Michigan Department of Public Health show 160,815 births for 1966. This compares to 161,105 reported for the previous year. Late reports will bring the figure higher. The rate has steadily dropped since a high of 207,277 births in 1957.

mediscene

Sept. 14-16 — Central Association of Obstetricians and Gynecologists, Detroit

Sept. 14-16 — Annual Meeting of the American Thyroid Association, University of Michigan Medical School, Ann Arbor

Sept. 24-26 — MSMS House of Delegates, Black and Silver Room, Civic Auditorium, Grand Rapids

Sept. 26-28 — MSMS Woman's Auxiliary, Pantlind Hotel, Grand Rapids

Sept. 27 — MSMS Dinner Dance, Pantlind Hotel, Grand Rapids

Sept. 27-28 — Diet Therapy Conference, Pantlind Hotel, Grand Rapids

Sept. 27-28 — Michigan State Medical Assistants Society Convention, Morton House, Grand Rapids

Sept. 27-29 — MSMS Annual Scientific Session, Civic Auditorium, Grand Rapids

Sept. 29-Oct. 1 — American Academy of Child Psychiatry, University of Michigan Medical School, Ann Arbor

Oct. 5-7 — Medical School Alumni Reunion, University of Michigan Medical School, Ann Arbor

Oct. 9-13 — International Conference on Leukemia and Lymphoma, University of Michigan Medical School, Ann Arbor

Oct. 15-21 — National Community Health Week

Oct. 27-28 — Regional Meeting, American College of Physicians, University of Michigan Medical School, Ann Arbor

Nov. 2 — Southwestern Michigan Clinic Day

Nov. 8 — The Council, MSMS Headquarters, East Lansing

Nov. 15-17 — International Conference on Fertility and Family Planning — A World View, University of Michigan Medical School, Ann Arbor

Nov. 26-29 — AMA Clinical Convention, Houston

Nov. 26-29 — Conference on Genetics in Medicine, sponsored by the American College of Physicians, University of Michigan Medical School, Ann Arbor

Dec. 13 — The Council, MSMS Headquarters, East Lansing

March 26-27 — Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 23-28 — Student American Medical Association, Detroit

May 1-8 — Mental Health Week

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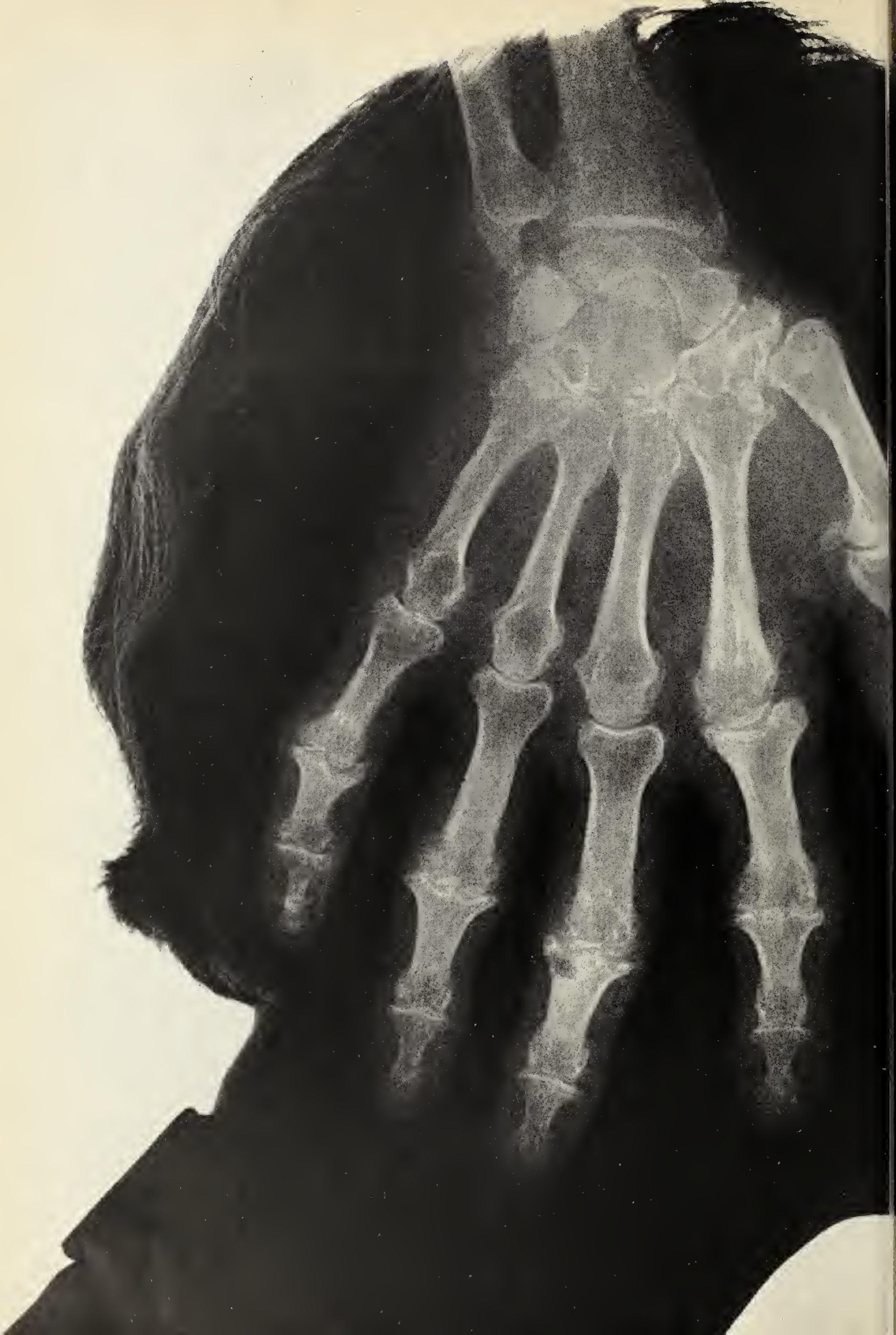

This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

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Wyeth®

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

NEW LAW EXPLAINED:

Protection Given Doctors Serving on Tissue Committees

Public Act 270 (SB 339) "To provide for the release of information for medical research and medical education purposes; to limit the liability with respect thereto; and to safeguard the confidential character thereof" was signed by Governor Romney on July 20, 1967 and given immediate effect.

The AMA has urged state societies to seek legal protection for physicians who are members of tissue or utilization committees, to provide them with immunity from liability when reviewing the qualifications of fellow physicians, to help maintain high standards of patient care.

The Bill was introduced by Senators Richardson, Lodge, Flemming, Brown and Craig. MSMS expresses its deep appreciation to these senators for their help in gaining acceptance of this new law.

MSMS urged and supported the enactment of this legislation by testimony given to both the Senate and House Committees and by providing informational data to the two committees.

THE ENTIRE ACT is as follows:

The People of The State of Michigan Enact:

Sec. 1. Any person, hospital, sanitorium, nursing or rest home or other organization may provide information, interviews, reports, statements, memoranda or other data relating to the condition and treatment of any person to any in-hospital medical staff committee, to be used in the course of any study for the purpose of reducing morbidity or mortality. No information, interviews, reports, statements, memoranda or other data relating to the condition and treatment of any person shall be released if the patient or his guardian shall object in writing. No liability of any kind or character for damages or other relief shall arise or be enforced against any person or organization by reason of having provided such information or material, or by reason of having released or published the findings and conclusions of such staff committee to advance medical research and medical education, or by reason of having released or published generally a summary of such studies in accordance with this section.

Sec. 2. Any in-hospital medical staff committee shall use or publish said material only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released by any such committee for general publication.

Sec. 3. The identify of any person whose condition or treatment has been studied shall be confidential and shall not be revealed, and this section shall apply to sections 1 and 2.

PA 270 CONTAINS necessary and desirable safeguards for both patient and doctor in that quality care can be assessed without invading the patient's privacy or subjecting the physicians to liability for defamation of character, invasion of privacy, etc.

Robert J. Mason, M.D., MSMS Council Chairman, said: "This law will provide a practical and acceptable means for the dissemination of knowledge and experience gained in actual cases, for research and educational purposes."

And C. Allen Payne, M.D., MSMS President, said, "I am elated at the passage of this needed legislation and I extend my thanks to the Legislative and Executive branches of our Government and to the MSMS Legal Affairs Committee and staff."

M.D. Placement

- —Looking for a smaller town that needs and wants a physician?
- —Do you need an associate or assistant in your practice?
- —Are there towns in your area in need of additional physicians?
- —If your answer is YES to any of the above questions, contact

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John A. Doherty, Executive Secretary
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East Lansing (Phone: 337-1615)
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DU-5255

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Few drugs work as predictably as Dulcolax. You can expect that when your office patient takes Dulcolax at home, it will be as effective as you said it would be. Your patient will be gratified, too.

The reliability of Dulcolax stems from its unique mode of action. The drug works directly on nerve endings in the colonic mucosa, producing normal peristalsis throughout the large intestine. It does not rely on systemic absorption for its effect.

This reliable action provides prompt relief of constipation. It also makes Dulcolax particulary useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.

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9 3
8 4
7 6 5
predictable bowel evacuation

Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

General Dosage Information: *Adults:* When an ordinary laxative effect is desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets must be swallowed whole, not chewed or crushed, and should not be taken within one hour of antacids or milk. *Children:* 1 or 2 tablets, depending on age and severity of condition. Tablets must not be given to a child too young to swallow them whole. For infants and children under 2 years of age, half a suppository is usually effective. Above this age a whole suppository is usually advisable. Side Effects: As with any laxative, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

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Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.

You may be prescribing Hygroton®, chlorthalidone

You usually prescribe one tablet daily, but every once in a while you like to cut the dosage. So instead of giving the 100 mg. tablet every other day or breaking it in half, why not prescribe the new half-strength tablet every day?

See next page for a brief precautionary statement.

but you
don't know the
half of it.

New Hygroton
50 mg.

For a clinical supply,
please mail us this coupon
with one of your
prescription blanks.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

DEPT. 7

Broad scope diuretic

Hygroton®
chlorthalidone

Hygroton is indicated in certain conditions where the newer nonthiazide diuretics are not recommended, e.g. hypertension, edema of pregnancy, premenstrual edema, edema in obesity states, steroid edema.

However, the newer diuretics are probably superior to Hygroton in acute pulmonary edema and the nephrotic syndrome or any condition where the glomerular filtration rate is significantly low.

Geigy

Indications

Hypertension

Such as hypertension with or without congestive failure, where Hygroton can be used alone or in conjunction with other agents
(*Precaution:* Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension.)

Edema

Such as edema associated with:
congestive heart failure
or renal disease
(*Precaution:* Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises.)
or hepatic cirrhosis
(Hypoproteinemia, if present, must be corrected concomitantly. *Precaution:* Take special care: discontinue if liver dysfunction is aggravated, since hepatic coma may be precipitated.)
or steroid administration
or obesity
or the premenstrual syndrome
or pregnancy, including toxemia
(*Warning:* Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult, e.g. thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc., are potential problems in the newborn.)

Contraindications

Severe Renal or Hepatic Disease and Demonstrated Hypersensitivity

Other general warnings, precautions and adverse reactions

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Precautions: Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in severe ischemic heart disease and in patients receivin corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, dysuria, impotence, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonge administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50-100 mg. with breakfast daily.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg. in bottles of 100 and 1000.

Please see full Prescribing Informatio

Geigy Pharmaceuticals
Division of Geigy Chemical Corporatio
Ardsley, New York 10502

HY-521

Fears Patient Smothering Under Bureaucratic Tape

EXCERPTED FROM EDITORIAL
IN ESCANABA DAILY PRESS

"Half a century ago we were just entering World War I and all the stimulation that it brought to the global view and scientific progress. There has been no pause since in the accelerated pace of medical progress.

"Our physicians have been able, with the stimulation of American brilliance and affluence, to put together a complex of research, facilities and clinical practice that makes American medicine and surgery the best in the world. We have not done as well as some other nations in maternal deaths and some other categories, but American medicine and surgery at their best are unexcelled.

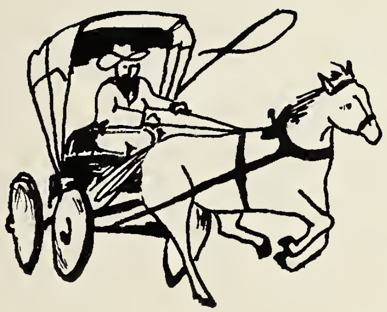
"The government snarl in the medical skein is inevitable, but it is remindful of the leeches that apothecaries used to sell to men with black eyes in much less complicated times. The nation has pretty much flaunted the counsel of medical conservatives about our capabilities to quickly socialize the national medical establishment and we're now in the process of beginning to find out that it's easier to give everyone a free pass to the doctor's office than it is to provide the services which will validate the passes.

"Medicare, with its huge burden of tax-paid care of the elderly, was superimposed on the nation's medical establishment without much thought about capacities, because it was deemed humanely and politically desirable. Now Medicaid is being launched by steps as the state can find the millions it will require.

"The size of the bureaucracy that will grow out of these huge efforts is only now beginning to be defined and it is giving concern to the medical profession. The patient may be rescued by fine medical service only to be smothered under red tape and a huge new cost of accounting is being created in a situation where health is increasingly high-priced.

"Change from a rural to an urban society, from a pastoral to an industrial society, from a small city to a big city society, and from an individualistic, free enterprise society to a big government, welfare-oriented society has affected American medical practice greatly.

"The profession still controls standards of practice but government is increasing its regulation of practice, especially through control of huge medical aid programs under social welfare legislation and under Social Security's Medicare for hospitalization of the elderly and the federal-state Medicaid program for care of the needy."



For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, $2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.

Up to the Public

Excerpted from "Michigan Mirror,"
Weekly Column by Elmer E. White,
Executive Director, Michigan Press Association

"The outlook is not encouraging. The need for doctors is still increasing faster than supply. Demands of the military service have added to the problem. In 1962, Michigan had 277 medical doctors in service. The current figure is 622.

"The number of people in age groups which require the most medical attention is also growing.

"The solution lies with the public. If the state is to build additional medical facilities, public monies must be spent. Legislators must be convinced by constituents that the need is worthy of appropriation."

WSU Medical School Gets Dodo of Gift From Class of '67

Gordon H. Scott, Ph.D., Vice-President of Medical School Development at Wayne State, and Mary Gaggos, a secretary at the medical school, examine "Winter Bronze."

BY PETER HOHEISEL
OF THE MSMS STAFF

"It's weird but cool, groovey," a white-frocked female medical student remarks as she heads for the cafeteria.

"It's a dead bird in winter who didn't fly south. Shows what happens," comments another student.

Source of the discussion is "Winter Bronze," a large piece of sculpture donated to the medical school by the senior class this year.

Created by Bill Rodwell, in his studio at Woodward and Warren, quips about the piece range from "It's profound," to "It's ugly."

Whatever the reaction, however, all agree that the work is remarkably well-done. Rodwell feels that from a critical point of view the subject matter of a work of art is not of prime importance. "It should be seen first as a piece of sculpture," he says. "Most people ask 'What is it?' or 'What does it mean?' The important question is: 'As a piece of sculpture is it good or bad?' "

But medical students are inveterate rationalists and discussion about what the work is and means inevitably arises after the initial reaction.

All agree that it is a bird who is going through something painful.

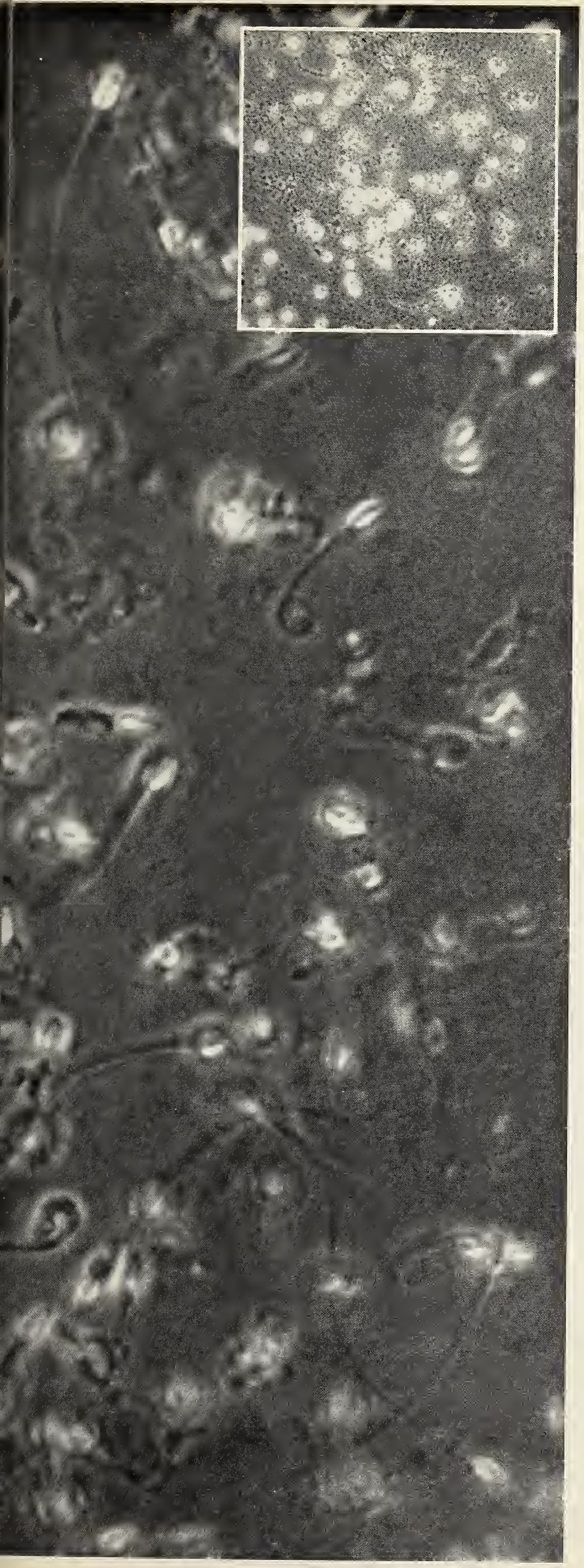
He may be dying. He may have just been born. Maybe he has just been born and is dying. No one knows for sure; perhaps from the artistic point of view it doesn't matter.

One analyst who sees deeply into the bird's symbolism says, "I think it's dead — a symbol of the suffering and sickness we are being trained to cure. It symbolizes what we're going to be doctors for."

"Winter Bronze" received this comment from Gordon H. Scott, Ph.D., former dean of the medical school and presently vice-president for medical school development: "It's a successful piece of realism, which it seems everyone wants these days."

"Of course I wouldn't want to sit and look at it all day," he added.

The Wayne State Medical School bird lies outside the door of the cafeteria. Sometimes he is ignored. Sometimes he gets a quizzical look suffused with a hint of sympathy. Sometimes a discussion develops over his agonized body. But he is surviving the wisecracks and ponderings and chances are he will be eliciting comment for some time to come.



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

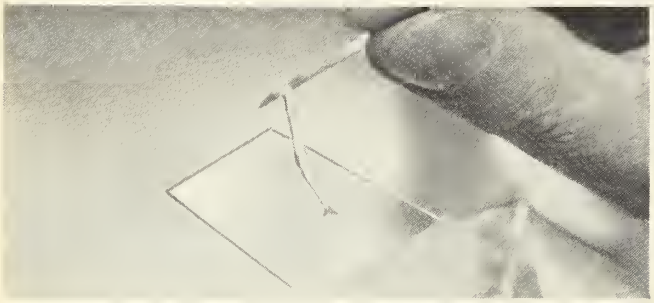
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

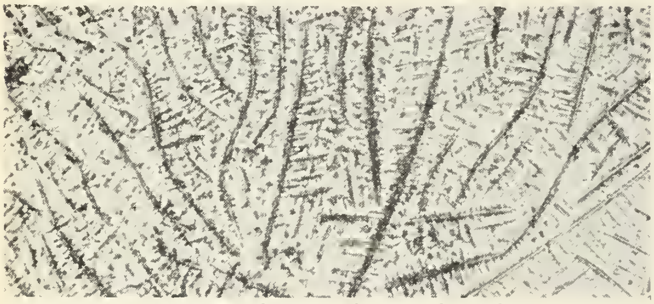
In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

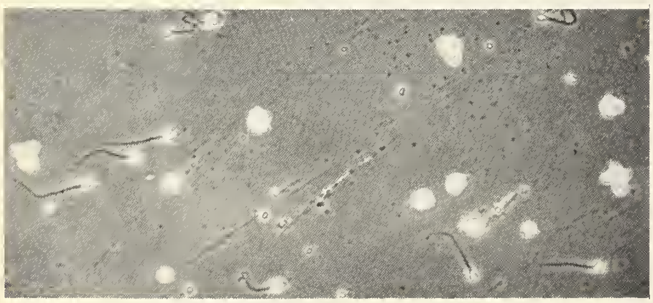
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

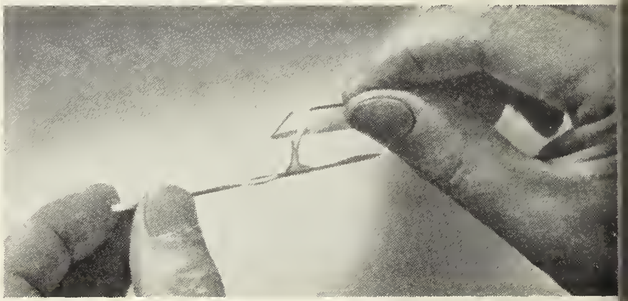


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

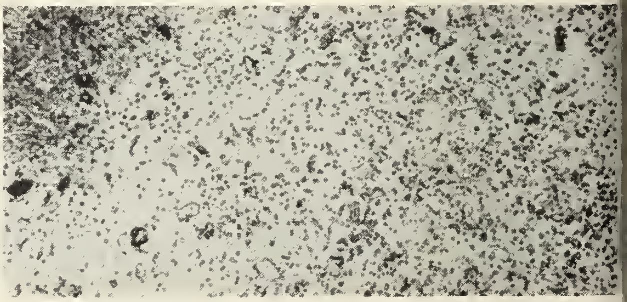


Spermatozoa appear healthy, are active and freemoving.

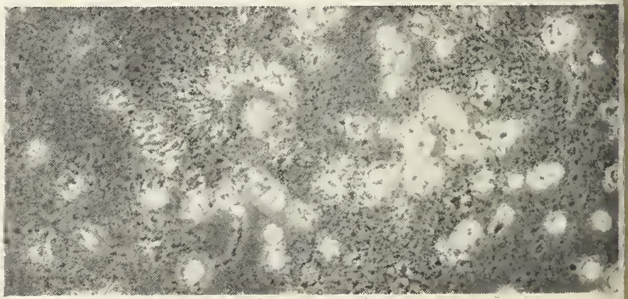
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

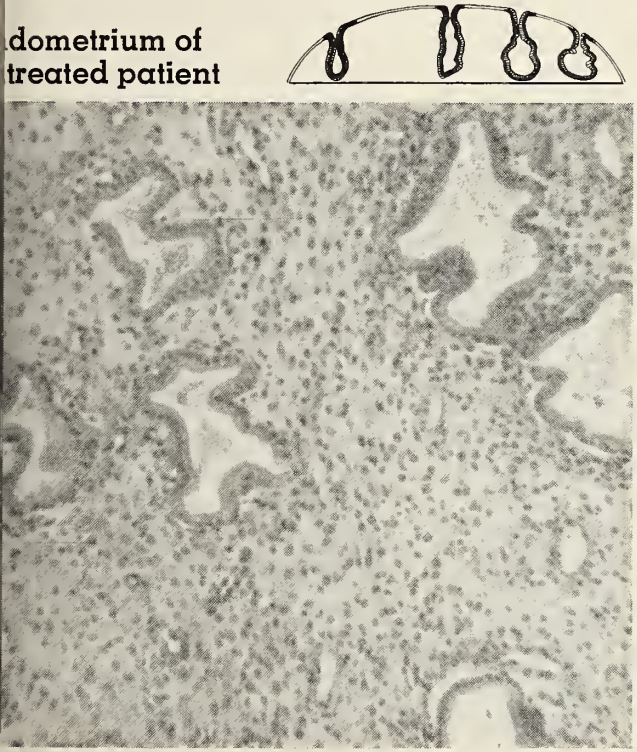


Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

ow Norinyl-1 lters normal ndometrial responses– nother possible rotective mechanism

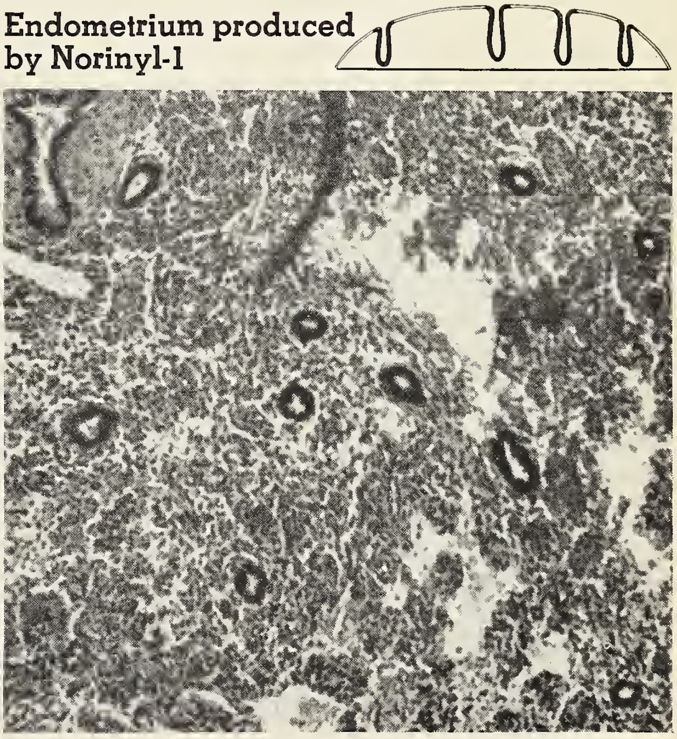
us suppose that an ovum is released—as occurs in an asional, rare case—and somehow a sperm succeeds in etrating the cervical mucus barrier. Should this come about, additional action of Norinyl-1 may protect the patient n unwanted pregnancy. The theory is that progestogen intake kes endometrial tissue unreceptive to implantation.

dometrium of
treated patient



rmally, the endometrium progresses through roliferative phase stimulated by estrogen and a cretory phase stimulated by progesterone. ring the secretory phase the endometrium is ceptive to the fertilized ovum.

Endometrium produced
by Norinyl-1



When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new **Norinyl-1**® tablets
(norethindrone 1mg. c̄ mestranol 0.05mg.)

e last page for contraindications, precautions, side effects and dosage.

effective fertility control on half the previous dosage

maintains ratio of the established norethindrone/mestranol combination

lower cost

new Norinyl-1® tablets

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Reduction of oral contraceptive dosage to lowest effective levels
become a well-accepted principle of conservative medical pract
In keeping with this view, Norinyl is now available in a new stren
in which *both* norethindrone and mestranol are reduced 50 perc
Studies show that Norinyl-1 achieves fertility control with only 1
mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent
human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg.,
an oral contraceptive, is currently in use by over 2,000,000 wom
Clinical experience now establishes that Norinyl-1 also amply me
the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be
altered by the use of oral contraceptives
creased bromsulphalein retention and o
hepatic function tests, coagulation tests
crease in prothrombin, factors VII, VIII, IX
X), thyroid function (increase in PBI and
nol extractable protein-bound iodine and
crease in T^3 values), metapyrone test, pregn
diol determination.

Other side effects reported to have occur
in association with use of this drug are d
ness, hirsutism, pains in legs, back, chest
abdomen, dysuria, drowsiness, vaginal
charge, libido increased and decreased, e
tions, hypermenorrhea, hypomenorr
increased appetite, G.U. infections, varic
veins, abdominal fullness, acne, heada
nervousness, allergies, blurred vision, pain
eyes, and itching in eyes. *For complete clini
data, see package insert.*

Dosage and Administration: 1. One tablet
Norinyl-1 is administered orally for 20 d
beginning on day 5 of the menstrual cy
(Count day 1 of the cycle as the first day
menstrual bleeding.) Repeat this dosage sc
ule for each cycle. 2. If no menstrual per
occurs after a cycle of treatment (20 tablets)
which patient adhered to the schedule, the
tient must be instructed to resume taking
Norinyl-1 tablets 7 days after the previous
day course was completed. For example, if
last pill of a previous cycle had been taken
a Sunday, then a new cycle of treatment sho
begin on the following Sunday. 3. In the p
partum woman, it is recommended that
first cycle of treatment should begin on da
of the first menstrual cycle. However, Norin
should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1
with mestranol 0.05 mg.)—Dispensers of 20 a
60 and bottles of 250 tablets.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

U-M MEMORIAL FUND HONORS H. H. CUMMINGS

The Howard H. Cummings Memorial Fund, in honor of the prominent Ann Arbor physician and Past MSMS President who died this past June, has been established at the University of Michigan.

Proceeds of the fund will go to the Department of Postgraduate Medicine at the University.

Physicians who wish to contribute to the fund can make checks payable to the University of Michigan Medical Center, account #35267, Postgraduate Building Fund.

WORTH WRITING FOR

Doctors are invited to write MSMS for a copy of a new booklet, *Drugs Anonymous,* which supports brand-drug prescribing.

Often doctors need such a booklet for interested patients.

The 15-page pamphlet published by Pharmaceutical Manufacturers Association discusses the naming of drugs and drug products, the role of official compendia, results of many drugs studies, and the importance of manufacturer identification in support of the concept of quality in the prescribing and dispensing of prescription medications.

For a copy, doctors may write to MSMS, 120 West Saginaw, East Lansing 48823.

Hanlon Will Direct APHA in 1967-68

John J. Hanlon, M.D., Detroit-Wayne County Health Commissioner, will be installed as president of the American Public Health Association, at the Association's annual meeting in October.

Doctor Hanlon is the second Detroit health commissioner to be so honored. Henry Vaughn, M.D., held the high office in 1925.

Hospital Management, New Northwood Program

Students will begin this fall a new two-year Hospital Unit Management Program which Northwood Institute in Midland has developed in order to train middle management personnel in hospitals.

One of the first colleges to offer the two-year hospital management degree, Northwood will devote 50% of its curriculum to hospital management and related courses, plus working experience at Midland hospital, and the other 50% to liberal arts courses.

Director of the program, which was made possible through a grant from the Midland Foundation for Advanced Research, is Kenneth W. Copp, Jr. Mr. Copp formerly was associated with the University of Michigan Department of Postgraduate Medicine.

★

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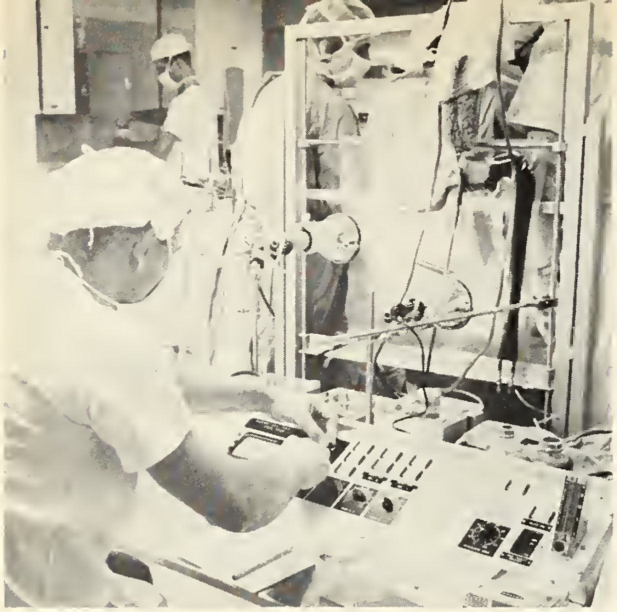

A technician checks the flow of blood through a mechanical heart during open-heart surgery on a dog at Ingham Medical Hospital. Lansing physicians and Michigan State University veterinarians have joined forces to save the hearts of dogs and gain long-term benefits for humans as well. For nearly two years now, George E. Eyster, D.V.M. heart surgeon at MSU, has had a close working relationship with William Weber, M.D., cardiologist at Ingham Medical, and medical doctors Seong Chi, Calvin Blair, and DoVan Suu, Ingham Medical heart surgeons. The physicians donate their time because of the new knowledge and experience that they gain.

Michigan Tech Offers CD Courses for Public

Michigan Technological University is now presenting to the medical profession and the public an opportunity to learn civil defense survival.

A 12-hour course entitled "Personal and Family Survival," is available free of charge for any group wishing to learn about disaster problems. The program includes the following topics: History and Public Laws of Civil Defense, The Warning Program from North American Air Defense (NORAD) Headquarters to the Local Community, The Effects of the Nuclear Weapon and the Nature of Fallout, The National and Local Shelter Program, The Psychological Problems of Shelter Living, Home Shelters, Natural Disaster Problems, and Community Shelter Planning. Michigan Technological University will furnish instructors for the course, and the office of U.S. Health, Education and Welfare will pay them through contractual arrangements.

For further information about the program contact Mr. William Burrell, Jr., State Coordinator, Michigan Technological University, 416 Frandor Center, Lansing, Michigan 48912 or your local Civil Defense director.

A View of the Future

I am going to make an optimistic prediction, based on my conviction that the medical practitioner must come to play an increasingly important role in the prevention and treatment of mental disorders.

I will predict that in the years to come, the medical student will be taught psychiatry in its appropriate context — the medical ward and the medical clinic — and not in the psychiatric hospital and the separate psychiatric clinic. I will predict that the newer kind of medical interview behavior which will result will be further reenforced during internship, residency training and postgraduate medical education. Thus, new medical interviewing techniques will permit the physician to deal with the whole patient rather than with isolated organ systems.

The role of the psychiatric consultant, as that of other consultants, will be to advise the family practitioner when asked to do so, and to treat only patients with complicated psychiatric disorders that are too time-consuming for the circumstances of family medical practice.

Family physicians will play a vital role in the function of community mental health centers, both in knowing how and when to make referrals to such centers and in contributing time to the actual functioning of such centers.

With the necessary knowledge of how to detect psychic disease and how to treat emotional disorders effectively, the family physician will prevent many of the instances of progression to chronic psychiatric illness with which we are now plagued. — Allen J. Enelow, M.D., Department of Psychiatry, University of Southern California School of Medicine, Los Angeles: "Prevention of Mental Disorder. The Role of the General Practitioner," *California Medicine,* 104:16-21.

MHA OFFERS FILM

A 48-minute, 16 mm, color, sound film called "Prescription for Life," designed to be a basis for training courses for doctors and nurses in emergency heart-lung resuscitation, is available loan-free from the Closed Chest Cardiac Resuscitation Coordinator of the Michigan Heart Association, 13100 Puritan, Detroit, Michigan 48227.

The film provides anatomic and physiologic experimental and clinical details on the ABCD's of emergency resuscitation: airway, breathing, circulation, and definitive treatment. After laboratory and demonstration sequences there are dramatic re-enactments of emergencies in operating or emergency rooms, intensive care units, hospital wards, and some outside emergency situations.

Print is the meat and potatoes that feed the powers of reasoning.

—Charles A. Sprague, Editor
Oregon Statesman,
In Quill, June, 1967

EUKEMIA CONFERENCE
CT. 9-13 AT U-M

Muriel C. Meyers, M.D., of the University of ichigan, and Wolf Zuelzer, M.D., from Chilren's Hospital in Detroit, will be joining other minent speakers at the International Conference n Leukemia-Lymphoma in Ann Arbor, October -13. Doctor Meyers will discuss “Treatment of cute Leukemia in Adults” and Doctor Zuelzer, In Children.”

The etiology and epidemiology of leukemia-mphomas will be the focus of the program, long with biochemical aspects of these diseases, oncluded by study of recent trends and treatents.

The July issue of *Michigan Medicine* carried a omplete list of the speakers; for handy reference e page 903 of that issue.

Upjohn Official Joins PMA Fund Committee

Harold L. Upjohn, M.D., Director of Medical Research, The Upjohn Company of Kalamazoo, has been named a member of the ten-man scientific advisory committee of the Pharmaceutical Manufacturers Association.

The Committee, advisory to the Board of Directors of the Pharmaceutical Manufacturers Association Foundation, Inc., makes recommendations on grant requests and suggests programs which the PMA Foundation may wish to establish.

The PMA Foundation was founded in 1965 by the PMA “to promote the public health through the study and development of the science of therapeutics.” Since its formation, the Foundation has authorized expenditures of nearly $1 million for research in drug toxicology and training programs in the field of clinical pharmacology.

Offer Psychiatric Symposium

A research Symposium on Psychiatric Emergencies will be presented by the Department of Psychiatry, University of Michigan Medical Center, October 5-6. Enrollment will be limited by the available facilities. Further information can be obtained from R. W. Waggoner, M.D., or W. H. Van Houten, M.D., University Medical Center, Ann Arbor.

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Business Meetings Of MSMS Sections

Section on Allergy and Applied Immunology, Wednesday, September 27, Room C, Civic Auditorium, 3:15-4:15 pm

Section on Anesthesiology and The Michigan Society of Anesthesiologists, Inc., Wednesday, September 27, Room D, Civic Auditorium, 11:45 am to 12:00 noon

Section on Dermatology, Wednesday, September 27, Room C, Civic Auditorium, 11:45 am to 12:00 noon

Section on Gastroenterology, Friday, September 29, Room C, Civic Auditorium, 11:45 am to 12:00 noon

Section on General Practice, Thursday, September 28, Black and Silver Room, Civic Auditorium, 11:45 am to 12:00 noon

Section on Gynecology and Obstetrics, Thursday, September 28, Room C, Civic Auditorium, 5:15 to 5:30 pm

Section on Internal Medicine, Wednesday, September 27, Black and Silver Room, Civic Auditorium, 11:45 am to 12:00 noon

Michigan Association of Neurological Surgeons (Section of Neurological Surgery), Thursday, September 28, 6:00 pm dinner-meeting at Lakos Restaurant.

Section on Occupational Medicine, Thursday, September 28, Room D, Civic Auditorium, 9:45 to 10:00 am

Section on Ophthalmology and the Michigan Ophthalmological Society, Thursday, September 28, Red Room, Civic Auditorium, 5:15 to 5:30 pm. A reception will follow the meeting.

Section on Otolaryngology, Thursday, September 28, Red Room, Civic Auditorium, 3:00 to 3:15 pm

Section on Orthopedic Surgery, Thursday, September 28, Room C, Civic Auditorium, 11:45 am to 12:00 noon

Section on Pathology—no meeting in 1967

Section on Pediatrics and the Michigan Branch of the Academy of Pediatrics, Thursday, September 28, 6:00 pm reception-dinner-meeting at the Peninsula Club.

Section on Plastic Surgery, Thursday, September 28, Room C, Civic Auditorium, 3:00 to 3:15 pm

Section on Proctology, Thursday, September 28, Room D, Civic Auditorium, 5:15 to 5:30 pm

Section on Psychiatry and Neurology, Thursday, September 28, 6:00 pm dinner-meeting. A joint meeting with the Michigan Society of Psychiatry and Neurology.

Section on Public Health and Preventive Medicine, Thursday, September 28, Room D, Civic Auditorium, 3:00 to 3:15 pm. A reception will follow.

Section on Radiology, Friday, September 29, Room D, Civic Auditorium, 11:45 am to 12:00 noon

Section on Surgery, Thursday, September 28, Room D, Civic Auditorium, 11:45 am to 12:00 noon

Section on Urology—not meeting in 1967.

Ford to Address MDPAC Breakfast

Gerald R. Ford, Congressman from Michigan's Fifth District and Minority Leader of the House of Representatives, will be the featured speaker at an MDPAC breakfast September 27 at 7:30 a.m., during the Annual Session.

All physicians and their wives are invited to attend the breakfast.

Vernon V. Bass, M.D., Saginaw, Chairman of MDPAC, will preside.

Alumni Notices

The University of Michigan Medical Center Alumni Society cordially invites alumni and friends to its Hospitality Suite in the Pantlind Hotel during the Michigan State Medical Society meeting. The Suite will be open Sunday afternoon through Thursday.

The Wayne State University School of Medicine Alumni Association will have a Hospitality Suite at the Pantlind Hotel. A special reception for all alumni, faculty, and friends will be held on Thursday, September 28, from 4 to 6 pm. Representatives of the University will be in attendance.

The Headquarters Suite will be maintained as follows:

Tuesday, September 26—11 am to 6 pm
Wednesday, September 27—11 am to 6 pm
Thursday, September 28—11 am to 6 pm

The Vanderbilt Alumni Association will also have a gathering during the meeting. A Cocktail Hour will be held Wednesday, September 27, from 6 to 7 p.m., in the Pantlind Hotel.

The University of Pennsylvania Medical School Alumni Association will entertain alumni and friends with a Cocktail Hour on Thursday, September 28, from 6 to 8 p.m. in the Pantlind Hotel.

Photo professionally posed

Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —PEN•VEE® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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Meetings of Related Groups

The Woman's Auxiliary to the Michigan State Medical Society will meet on Wednesday, September 27 in the Continental Room of the Pantlind Hotel from 8:45 AM to 11:30 AM. Luncheon will be held in the Kent State Room at 12 noon. The afternoon session will start at 2:00 PM and will be held in the Sadler Lounge. On Thursday, September 28, the Auxiliary will meet at 8:45 AM in the Continental Room of the Pantlind Hotel with luncheon at 12:30 in the Kent State Room. A post-convention Board meeting will follow the luncheon.

The Michigan State Medical Assistants Society will hold their annual convention in the Morton House in Grand Rapids beginning at 8:00 AM on Wednesday, September 27 and continuing through luncheon on Thursday, September 28.

Michigan Doctors Political Action Committee (MDPAC) will hold a breakfast meeting at 7:30 AM on Wednesday, September 27, 1967. Tickets can be secured in advance by contacting the MDPAC office, P. O. Box 169, East Lansing, Michigan 48823. Cost is $2.00. Location of breakfast has not been ascertained but will be in the Pantlind Hotel in Grand Rapids. Minority leader of the U. S. House of Representatives, Congressman Gerald Ford, will be the speaker.

The Michigan Society of Psychiatry and Neurology will meet on Thursday, September 28, as follows: 3:00 to 6:00 pm meeting of the Council; 6:00 reception-dinner-meeting of the Society with the MSMS Section on Psychiatry and Neurology. Following dinner, the meeting will adjourn so all in attendance may attend the forum on "Family Life and Sex Education."

The Michigan Branch of the Academy of Pediatrics and the **Section on Pediatrics** will have a 6:00 pm reception-dinner-meeting on Thursday, September 28 at the Peninsular Club (120 Ottawa St. NW, Grand Rapids). The pre-prandial and dinner are with the courtesy of the Gerber Products of Fremont. The speaker is H. William Clatworthy, M.D., of Columbus, Ohio who will talk on "Diagnosis and Management of Diseases of the Liver, Bile, Duct, and Portal System in Infants and Children." Reservations can be sent to John R. Wilson, M.D., 1033 W. Fulton St., Grand Rapids 49504 (616 GL 9-4245).

There will also be meetings of the following groups: the **West Michigan Branch of the Detroit Roentgen Ray and Radium Society**, the **Michigan Heart Association**, and the **Michigan Society of Internal Medicine.**

Concentrate All '67 Activities On Main Floor

The new floor plan for the 1967 Annual Session in Grand Rapids is good news for physicians who remember walking up and down stairs to get from exhibits to scientific meetings during previous annual sessions in Grand Rapids.

This year the registration desk and exhibits will all be on the first floor, rather than in the basement. The scientific meeting rooms also will be on the first floor.

The exhibition hall this year will be in the big Civic Auditorium ballroom, which in past was used only for some meal and socal functions.

One of the colorful and educational aspects of the MSMS Annual Session in Grand Rapids this September will be the interesting array of scientific and technical exhibits.

MSMS leaders say, "Take time to inspect each one — not just a look-see — but a real indepth study. You will be surprised at the wealth of new information they will offer you."

The only function to be held on the lower level will be the luncheons.

Intermission periods between scientific sessions will give the doctors additional opportunity to visit the exhibits.

1967 Conference on Nutrition and Diet Therapy in Michigan

Co-sponsored by
Michigan State Medical Society
and
Michigan Department of Public Health
in cooperation with
The University of Michigan Medical School
Wayne State University School of Medicine
Michigan State University
College of Human Medicine
Pantlind Hotel, Grand Rapids

WEDNESDAY, SEPTEMBER 27

9:00-
9:45 A.M. REGISTRATION
Opening Session
Presiding: Alice H. Smith
GREETINGS
C. Allen Payne, M.D.—M.S.M.S.
John A. Cowan, M.D.—M.D.P.H.
RENAL DISEASES
Normal Renal Physiology
Ronald Easterling, M.D.
University of Michigan Medical Center
Modified Terminal Renal Syndrome
George L. Bailey, M.D.
Peter Bent Brigham Hospital
Boston, Massachusetts
Diet Therapy
Dietitian—to be announced
Henry Ford Hospital

12 Noon Lunch—(on your own)

2:00 P.M. Afternoon Session
Presiding: W. B. Prothro, M.D.,
Director, Kent County
Health Department

ALCOHOLISM

Review of the Literature
Olaf Mickelsen, Ph.D.
Michigan State University
Metabolism and Caloric Value of Alcohol
Wilfred Westerfield, Ph.D.
Upstate Medical Center of the
State University of New York
at Syracuse

ALCOHOLISM/Continued

Michigan Programs
Hospital—Jan Mills,
St. Luke's Hospital, Saginaw
Local Health Department—
Marie Fecht,
Grand Rapids-Kent County
Health Department
State Health Department—
Matilda F. Stone, M.S.
Nutrition Section

THURSDAY, SEPTEMBER 28

9:00-
9:30 A.M. REGISTRATION
9:30 A.M. Presiding:
GERONTOLOGY
Biological and Physiological Changes as Related to Aging
Charles Barrows, M.D.
Gerontology Research Center
Baltimore City Hospitals
Effect of Nutrition on Life Span and Age Related Diseases
Morris Ross, M.D.
Institute for Cancer Research
Newark, Delaware

12 Noon Luncheon
Presiding: Martha J. Thomason, M.S.
New Thoughts on Old Age
Robert Kastenbaum, Ph.D.
Cushing Hospital
Framingham, Massachusetts

2:00 P.M. Presiding:
Human Nutrition Studies as Related to Age
Robert McGandy, M.D.
Harvard School of Public Health
Boston
Osteoporosis—A Unified Concept
Robert P. Heaney, M.D.
Creighton University School of Medicine
Omaha, Nebraska

"Have Lunch with the Speakers" Idea Promoted for 1967 Annual Session

Physicians whose questions did not get answered at past scientific meetings, either because they thought of them too late or there was not enough time, will have a chance to meet the speakers for informal discussion during the luncheons at the MSMS Annual Session this year.

Signs indicating where the guest speakers will sit during the luncheon will give physicians the opportunity to have lunch with any of the speakers.

Annual Session Program Committee is enthusiastic about this opportunity to get individual questions resolved. Tickets for the luncheons will be available at the MSMS Registration Area in the Civic Auditorium.

One luncheon has been scheduled for noon Wednesday and one for Thursday, September 27 and 28 on the lower level of the Grand Rapids Civic Auditorium. A cash bar will be set up prior to the luncheons.

Woman's Auxiliary Convention Offers New Program Ideas

The Woman's Auxiliary to the Michigan State Medical Society will meet for the 41st Annual Convention, September 26 through September 28, in the Continental Room of the Pantlind Hotel in Grand Rapids.

Mrs. Henry Scovill, Ypsilanti, President of the Auxiliary, will preside. Mrs. Willis Dixon, Grand Rapids, is the general chairman in charge of the convention.

While the convention will conduct the regular business of the annual meeting, an innovation has been introduced. Workshops will be held for the incoming officers and committee chairmen of the county auxiliaries to help those women who have accepted responsibilities in their local areas. Mrs. Scovill and the other officers urge the leaders of the county auxiliaries to attend.

Another innovation will be presented at this convention. County auxiliaries have been asked to present the past year's work of their society in the form of pictures of their outstanding activities.

The State Board of the Auxiliary will meet at a luncheon on Tuesday, September 26 and the Board of Directors will formally convene following this luncheon.

In addition to the business meetings and workshops, luncheons will be held Wednesday and Thursday. A theatrical sketch will be offered at the Wednesday luncheon and an outstanding speaker will be present at the Thursday luncheon.

Officers will be installed at the Thursday luncheon and a representative of the Woman's Auxiliary of the AMA will be the installing officer. The presidents and presidents-elect of the state auxiliaries of Illinois, Ohio, Indiana and Wisconsin have been invited to attend and will be formally presented at the convention.

Plan Sex Education Seminar; Invite Public

Response to the open forum on VD during the 1966 Annual Session was so great that MSMS plans a similar program devoted to Family Life Education on Thursday evening, September 28, during the 1967 Annual Session.

The program will be open to interested physicians and the public.

Speaker for the meeting, to be held in the Ballroom of the Pantlind Hotel, will be Esther D. Schulz, Ph.D., R.N., Associate Director for Education Services of the Sex Information Education Council of the U.S. Her topic will be "Family Life and Sex Education — Neglect or Overemphasis."

The meeting will be sponsored by the Section on Public Health and Preventive Medicine of which Robert E. Rowe, M.D., Port Huron, is the Chairman and Eleanor P. Skufis, M.D., Adrian, is the Secretary.

The meeting is also sponsored by the Committee of Maternal Health and its subcommittee on Lay Education. William W. Jack, M.D., Grand Rapids, is Chairman of the Maternal Health Committee and James E. Harryman, M.D., Muskegon, is Chairman of the Subcommittee.

MSMAS Convention Plans Progressing; Sept. 26-27-28

The 18th annual convention of MSMAS will be eld at the Morton House in Grand Rapids, Sepember 26 through September 28.

All medical assistants, whether or not they are members, are cordially invited to attend.

Mrs. Alta Greene, Battle Creek, President of the Michigan State Medical Assistants Society, will reside.

Three of the speakers are Herbert A. Raskin, M.D., Clinical Associate Professor, Department of Psychology, Wayne State University School of Medicine, who will discuss "Drug Dependency;" Frederick J. Margolis, M.D., of Kalamazoo, who will discuss his film "Parent to Child About Sex;" nd Esther D. Schulz, Ph.D., Associate Moderator or Education Services, Sex Information Council of the United States, New York, who will speak on "Family Life and Sex Education — Neglect or Overemphasis."

Registration, a hospitality hour and campaign parties will be held from 6:00 to 10:00 p.m. on Tuesday, September 26.

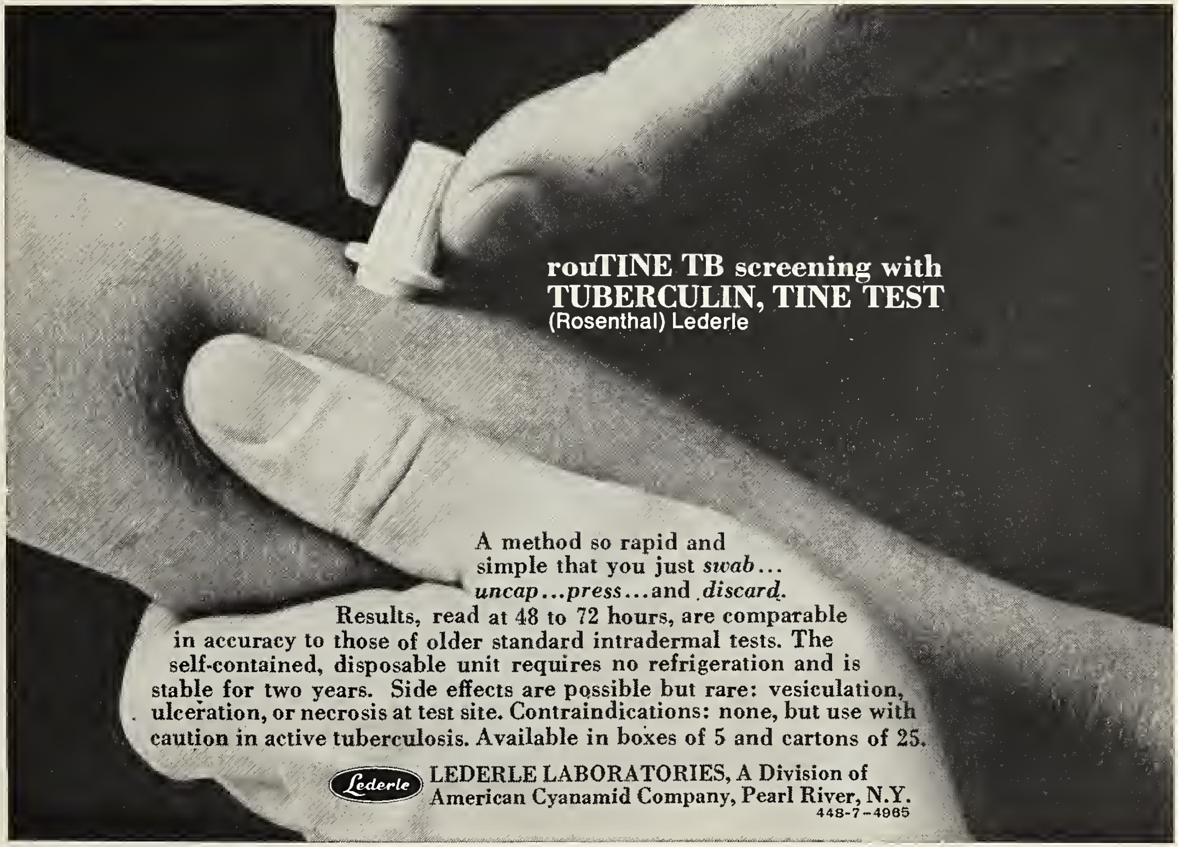
The MSMAS House of Delegates will formally convene at 8:00 AM, September 27, according to Mrs. Dorothy Brandis of Lansing, who is the Speaker.

The banquet will be held on Wednesday evening, September 27 with Mrs. Greene as chairman. In addition to a speaker, "The Medical Assistant of the Year" will be given her award.

Awards will also be made to the county society making the biggest increase in membership during the past year, and to the county society having the most outstanding county bulletin, according to the judges. Mrs. Betty Attaway of Flint is the awards chairman.

New officers will be installed at the luncheon on Thursday, September 28. Mrs. Warner is hostess of this luncheon and the "Past President's Award," given annually by Michigan Blue Shield, will be presented by John Verbiest of that organization.

Mrs. Dorothy Warner, Kalamazoo, First Vice President, is chairman of the convention and Miss Phyllis Marquardt, also of Kalamazoo, is the chairman of the Program Committee.


rouTINE TB screening with TUBERCULIN, TINE TEST
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A method so rapid and simple that you just *swab... uncap...press...*and *discard*. Results, read at 48 to 72 hours, are comparable in accuracy to those of older standard intradermal tests. The self-contained, disposable unit requires no refrigeration and is stable for two years. Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in boxes of 5 and cartons of 25.

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THE OPTIMUM-NUTRITION INFANT FORMULA

OPTIMUM CONTENTMENT

New Optimil's marked superiority in achieving satiety — reflected by infants' infrequent crying — is most reassuring to mothers.

Excessive appetite and inordinate crying in the infant are symptoms of essential fatty-acid deficiency. There may be insufficient linoleic acid in the diet, or the conversion of linoleic to metabolically-active arachidonic acid may be blocked by an inhibitory fatty acid. Optimil maintains optimum tissue levels of arachidonic acid by providing linoleic acid at 9% of total calories, with only a trace of linolenic acid, the potent blocking agent.[1-5]

OPTIMUM DIGESTIBILITY

New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.[6] (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

OPTIMUM GROWTH

New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Because Optimil is so similar to human milk and maintains high tissue levels of arachidonic acid, it offers superior caloric efficiency for optimum growth. The protein and mineral content is lower than that of any competitive infant formula. Therefore the osmolarity of Optimil is also the lowest. This extended formula has demonstrated its ability to provide optimum growth in comparative studies with leading modified-milk infant formulas.[7-9]

Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.

1. Hepner, R., et al.: Pediatrics 33:94, 1964. 2. Hepner, R., et al.: Pediatrics (to be published). 3. Hansen, A. E., et al.: Pediatrics 31:171, 1963. 4. Holman, R. T.: Fed. Proceed. 23:1062, 1964. 5. Holman, R. T., et al.: Amer. J. Clin. Nut. 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: J. Nut. 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: ibid. 9. Nichols, M.: ibid.

Optimil
Infant Formula
Carnation

Optimil, the first optimum-nutrition infant formula

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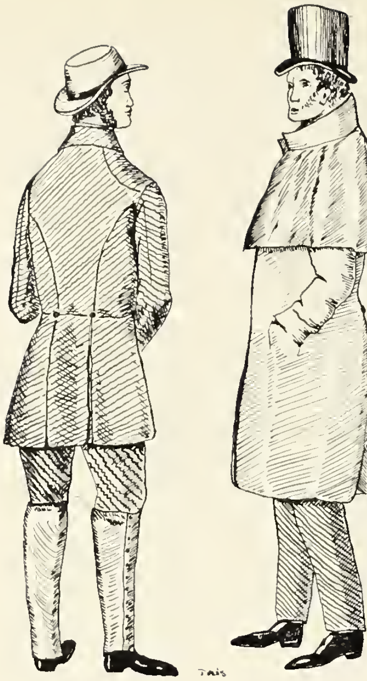
from a world leader in nutritional research . . . **Carnation®**



"Saddlebag Doctor," written by William R. Vis MD, Grand Rapids, is a historical novel abou the settlement of Grand Rapids and its first physicians, Charles Shephard, MD, and his friend Stephen A. Wilson, MD. The following chapte recalling an incident 130-140 years ago, is entitled "Medical Enigma." (The book was published b Wm. B. Eerdman, Publishing Company, Gran Rapids, in 1964. The Library of Congress Catalo Card Number is 6422033.)

Book about Michigan Medical History Dramatizes Problems in Getting Drugs

"What's new in medical circles, Willsie?" aske Shepard one evening at dinner.

"Well, nothing very spectacular, I guess. Sa my first case of chlorosis today."

"Hmmm," pondered Shepard, "chlorosis, yo say?"

"Now, Charlie, don't tell me you have forgotte Professor Richards' young lady in Senior Clas demonstration."

"Oh, yes, now I remember — the girl with th 'green sickness.'"

"That's what helped me to make the diagnosis this patient's complexion is pale but there is greenish tint to the skin."

Shepard asked: "How old is this girl?"

"Fifteen years, but she looks younger. A littl plump-flabby with fat, but soft and frail. Has t lie down much of the time. Apt to tire easily Claims she can't help her mother with the housework — with half a dozen other kids."

"Probably she is tired if she has chlorosis," offered Shepard.

"That's right. The mother tells me that formerly she thought her daughter was lazy, but latel she has suspected that her health is poor."

Shepard nodded. "Sounds typical, doesn't it The low blood count *would* sap her vitality."

"Sure would," agreed Wilson. "Now where will I get the iron to cure her? I could obtain some reduced-iron pills by sending to Detroit or Buffalo, perhaps, but that would take quite a while."

"Several weeks, at the earliest, surely. Might take a couple of months. I do have a small quantity of ferric iodide, which I will give you."

"Thanks; awfully kind of you. That will do to start with."

"Willsie, didn't we read somewhere about immersing iron bolts in acids to disolve the iron?"

"I can't remember, but we have iron in plenty around here, but where would be find the acid? If would have to be hydrochloric acid, I presume, to form iron chloride; and then the iron chloride could be dissolved in an elixir, I suppose. Yet, I woudn't know where to look for hydrochloric acid."

"What is the girl's name?" asked Shepard.

"Enithe Dalton," answered Wilson. "The family lives out Division Avenue, a couple of miles out in the township."

* * *

Dr. Wilson passed a restless night, thinking of pale, plump, impotent Enithe. Arising at dawn, he dressed meticulously, as was his wont, and sauntered out for a breath of air before breakfast. Few people were stirring so early, but at the corner of Pearl Street he encountered John Almy, who was in charge of the construction of Lucius Lyon's millrace.

"Morning, Doc," greeted Mr. Almy; "aren't you up pretty early this cold morning?"

"Good morning, Mr. Almy." Wilson nodded in agreement. "Rather early, I'd say."

"What's eating you, Doctor? You look worried!"

"Do I? Didn't know you could read my thoughts so easily."

"Well, you look a bit glum with your *chapeau* down over your eyes, your collar turned up, and your hands in your overcoat pockets. Hardly the picture of the successful young physician this breezy morning, I'd say."

"All right, all right, Almy; you're probably right. Don't mind if I walk with you? I'll tell you what's on my mind."

"Good enough; come along an' shoot the works!"

"Shepard and I were puzzling last night how we were going to obtain medicinal iron for a young girl patient of mine who has anemia. I thrashed around all night without getting any bright ideas."

"What is the chemical problem, exactly?" countered Mr. Almy.

"We thought we could take iron bars and derive ferric chloride with the use of hydrochloric acid. The chloride supposedly is soluble to a slight degree in water and elixirs."

"Perhaps so; I wouldn't know for sure."

"But we haven't any HCL!"

"No, I presume not; not chemically pure HCL, but there may be some muriatic acid for use in soldering in one of the foundries."

"Yeah!" mused Wilson, "muriatic is hydrochloric, isn't it? I hadn't thought of that. Thanks, Mr. Almy, that may solve the problem."

"Good; glad you mentioned the difficulty. If you have further trouble, I should be glad to help in any way possible."

* * *

Some weeks later, Mr. Almy inquired about further developments. "How did you come out with your chemical experiment?"

"Nothing to write home about," laughed Wilson, "but kind fate supplied some reduced-iron pills from Philadelphia which have done wonders for Enithe Dalton."

"Did you try the muriatic acid?"

"Yes, we did try it, but we had trouble dissolving the iron salts afterward. None of our elixirs seemed to absorb it very well. Might work in an emergency if nothing better were available, but thanks, just the same."

W. R. VIS, M.D.

AUTHOR OF "SADDLEBAG DOCTOR"

Extract of Council Minutes, July 14-15

The Council at its midsummer meeting met with representatives of various organizations to discuss matters of mutual interest, including representatives of the Michigan Department of Social Services, Michigan Medical Service, Michigan Health Council, Michigan Hospital Association, and Michigan Hospital Service, and the American Medical Association. Guests of The Council were: AMA Immediate Past President Charles Hudson, M.D., and AMA Executive Vice President F. J. L. Blasingame, M.D.

The Council adopted a policy statement to make it generally known to interested organizations The Council's whole-hearted support of fluoridation. This action was taken so that a current statement of policy would be on the record in addition to the long-standing policy expressed by the House of Delegates.

The Council appointed a committee for liaison with the Public Health Advisory Committee composed of three past presidents who would be able to reflect the policies of Michigan medicine.

The Council also authorized nominations for American Medical Association Council and Committee appointments to be submitted to the AMA Board of Trustees.

The Council met in extended sessions with the officers and the Medical Advisory Committee of Michigan Medical Service to discuss in detail the proposed new Blue Shield benefit program and variable fee plan. The Council took specific action to make recommendations for change to the Blue Shield Board of Directors. These actions of The Council and explanation of the new program were sent as authorized to each member of MSMS in early August.

The Council approved the Finance Committee's recommendations for budget revisions increasing the projected annual income and budgeted annual expences for a net gain in a fiscal '67 operation of $4,735.

The Council approved the recommendation to the Finance Committee after reviewing in detail Treasurer Ylvisaker's formal recommendations re revision of MSMS asset management and the establishment of basic investment policies. The recommendations of the Treasurer, as amended by the Finance Committee, were approved by The Council and referred to the House of Delegates for action.

The Committee on Respiratory Diseases recommended "That The Council recommend to all hospitals in Michigan that they discontinue the sale of cigarettes within the hospital. This would clearly indicate the medical profession's stand on cigarette smoking." The Council approved this recommendation.

The Council also authorized a meeting of scientific committee chairmen and others interested in heart-cancer-stroke in order to allow these persons to discuss the part to be taken by MSMS in the many plans now being made.

The Council disapproved a request that MSMS Medi-Labels be distributed by responsible lay organizations.

The annual reports of MSMS committees were reviewed by The Council and referred to the House of Delegates.

Representatives of the MSMS Judicial Commission, Donald M. Sweeny, Jr., M.D., Chairman, and Harold A. Furlong, M.D., Vice-Chairman, discussed matters of mutual interest with The Council.

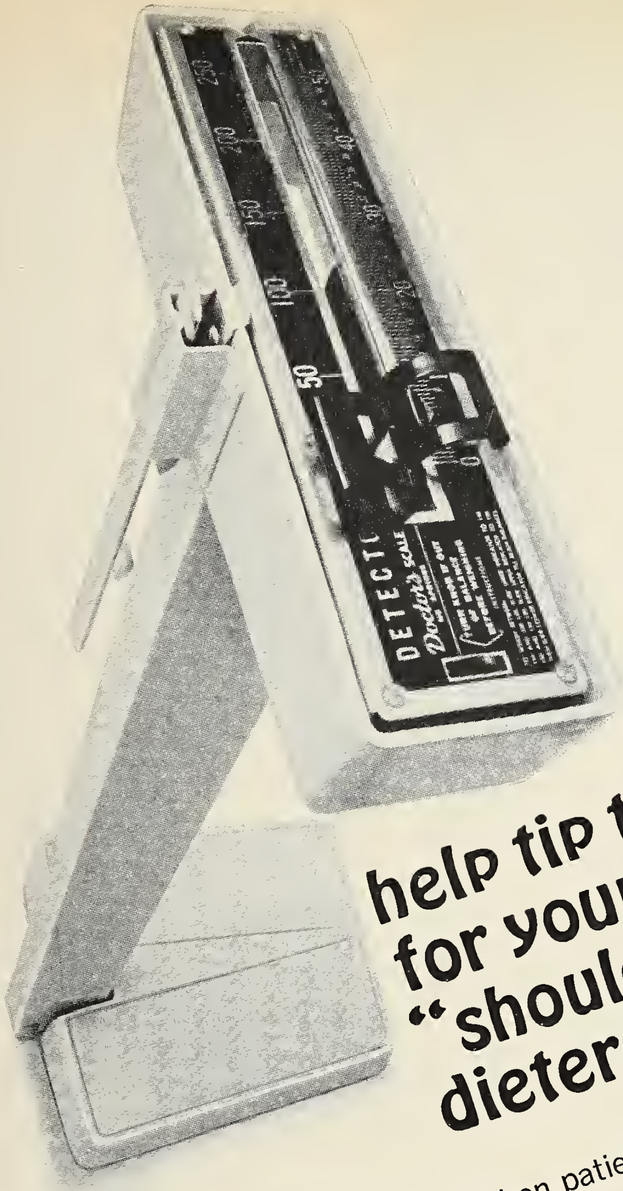
The Council authorized the Advisory Committee to the Executive Director to study and redefine the duties of the secretary and the treasurer.

Urges Attendance at Annual Session

"Medical knowledge has been growing so rapidly that no practitioner can safely rely on what he learned as a student or resident or consider his own resources as adequate for optimal patient care. It is more true now than ever before that a physician in order to remain highly competent must continue to be a serious student throughout his entire professional life.

"This challenge to continually improve and up-date ones medical knowledge increases with the number of years one is in medical practice."

—C. Allen Payne, M.D.
(Excerpted from MSMS President's Message; April, 1967)



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AMODEX® Timed capsules
Each AMODEX TIMED CAPSULE contains:

dextro-amphetamine HC1	15 mg.
amobarbital (barbituric acid derivative)	60 mg.

WARNING: may be habit forming

DOSAGE: One capsule on arising or at breakfast. Drugs are released gradually over 6 to 8 hours, providing therapeutic effect for 10 to 12 hours.

INDICATIONS: AMODEX Timed Capsules elevate the mood, relieve nervous tension, restore emotional stability and emotional capacity for physical and mental effort. AMODEX Timed Capsules are extremely useful in the treatment of anxiety states and may be used to control appetite in the management of the obese patient — without nervous excitation.

SIDE EFFECTS AND PRECAUTIONS: Frequent or continued use may cause nervousness, sleeplessness, or restlessness. Individuals suffering from high blood pressure, heart disease, diabetes, thyroid disease, lung ailments, or kidney disorders should not take this product. It should not be taken over a long period of time.

CONTRAINDICATIONS: Hyperexcitability, agitated pre-psychotic states. Sensitivity to Amphetamines or Barbiturates.

CAUTION: Federal Law prohibits dispensing without prescription.

SUPPLIED: In bottles of 30, 100, and 1000 capsules.

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DIVISION OF FELLOWS MEDICAL MFG. CO., INC.
pharmaceuticals since 1866
Detroit, Michigan

Discussing a complex case in the Midland Family Practice Program are, from left to right: Laurance A. Marshburn, M.D., David W. Knox, M.D., Scott Arnold, M.D., and Albert Duggan, M.D.

Unique Midland Hospital Program Develops Family Practice Physicians

BY PETER HOHEISEL
OF THE MSMS STAFF

Midland General Hospital now has a program designed to help meet one of the greatest problems facing medicine today — the diminishing supply of general practitioners.

Call these physicians what you will, general practitioners, family practice physicians, comprehensive care specialists, they are the front-line doctors who have the overall medical care of people as their responsibility.

At present four young physicians, Scott Arnold, M.D., David W. Knox, M.D., Laurance A. Marshburn, M.D., and Albert Duggan, M.D., are training at Midland General Hospital in the Family Practice Program. Three other men will join the program in December to participate in the 2½-year course designed to train family physicians.

IN THE WORDS OF David G. Dickinson, M.D., Family Practice Program Coordinator at the University of Michigan, which sponsors the Midland program, "The Millis Report articulated the crucial problem of the dwindling supply of physicians who give personal health care in contrast to those who give episodic care of disease. Medical schools have a major responsibility in supplying family practitioners, and the program at Midland is one way of meeting this responsibility."

"One of the major reasons for the lack of general practitioners," Doctor Dickinson explained, "is that the explosion of scientific knowledge and the attendant necessity of medical education tends to make a physician feel more secure in a specialty."

Another University of Michigan physician instrumental in founding the program is Harry A. Towsley, M.D., Director of Postgraduate Medicine. "We're trying," Doctor Towsley said, "to set up a top-flight program which will train excellent family practitioners. Because of the broad responsibilities of family practitioners, this will require a minimum of two years and possibly three years of training.

ALL OF THE YOUNG physicians in the program look forward to being family doctors because of the depth of involvement with people and because of the challenge of dealing with a wide variety of medical problems.

They are already experiencing involvement in a limited way through the Family Clinic Patient Care feature of the program. During the 2½ years of preparation each trainee is assigned to a certain number of families as their family physician. A staff physician works closely with the trainee as his preceptor in the care of the family clinic patients.

Also, during the entire program the young doctors spend approximately half a day working in the office of an attending physician.

"We see many things in a day here, not just specialized cases," says Albert Duggan, M.D., one of the program participants. "We work in the nergency room every third night and see every atient who comes in."

"When we admit a person," Duggan continued, we are assigned to follow his development until e leaves the hospital. Already we have people illing us at night for advice because they feel lose to us.

"Often, if you know a family's history well nough, you can almost predict what problems ill be coming," said Laurance Marshburn, M.D., nother of the trainees. Commenting further on e nature of general practice, he added, "In amily practice there is a constant change of pace, variety of problems."

THE FAMILY PRACTICE Program at Midland oes not replace the existing programs, but compments them, according to Robert E. Bowsher, I.D., Director of Medical Education at the hosital.

"If we don't teach the trainees anything but to now their limitations and when to ask for consulation and help, they will have gained a lot," octor Bowsher said in commenting on the obectives of the program.

"Also we try to get across to the young phyicians that they can't practice medicine on a 40-our week — there is the concept of availability which is important," he continued.

"We want the people in our program to recogize the patient as an individual, looking at him ot as a case or a disease entity, but as a whole uman being, as a member of a family and a ommunity. That is one of the gratifications of his type of practice," Doctor Bowsher said, "the development of a close personal relationship between the physician and his patient."

Before assuming his present position, Doctor Bowsher was for twenty years a general practitioner in Midland.

Robert E. Bowsher, M.D., Director of the Family Practice Program and of Medical Education at Midland General Hospital.

"We hope that our experience here will stimulate other similar programs throughout the state," Doctor Bowsher concluded.

THIS STRUCTURE of the Family Practice Program is as follows: The first 18 months are seen as one training unit. It includes six months of internal medicine and medical subspecialties; six months of pediatrics; three months of obstetrics-gynecology; three months of general surgery.

The last year of the program is tailored to the individual needs of the participants as determined by whether they intend to practice in a remote rural community or in a metropolitain area. Should a man elect rural practice, he will have three or four months additional experience in general surgery and in obstetrics and office gynecology. If big-city or community-hospital practice is his choice, he will receive three months of internal medicine, specializing in cardiology and pulmonary dseases, and three months of pediatrics.

Also a man may elect to spend the final year of his training in the preceptorship program. Here he may elect to spend the first six months of the year at the U of M Medical Center on services designed to complement the balance of the program before spending the final six months as a working assistant to a physician engaged in private practice.

THE SPONSORING PHYSICIAN in the preceptorship program will be expected to give the young physician an appropriate stipend as well as supervision and instruction.

That the Midland program will not by itself solve the problem of the need for family practice doctors is clear. But it is a unique creative step in that direction.

(Editor's Note: MSMS members interested in the possible development of "Physician's Assistants" to serve as extra helping hands are cordially invited to participate in two discussion workshops during the 1967 Annual Session in Grand Rapids. The following article offers some of the details.)

Annual Session Seminars to Ask Doctors To Consider Uses for "Physician's Assistants"

BY H. J. MEIER, M.D., CHAIRMAN
MSMS COMMITTEE ON
PARAMEDICAL EDUCATION

New concepts of medical education and method for providing health care are springing up all over the country.

Federal and state governments have now become an integral part of the health team and are planning to encourage the training of more and new types of paramedical personnel in order that health care be made the available right of every citizen.

The Michigan State Medical Society has been abreast of these developments and through its committee structure has been studying the feasibility of training a new category, a "physician's assistant."

The physician's assistant would be a career-oriented individual, trained within the structure of the physician's field in health care. The program would be designed to provide opportunities for men and women functioning under the direction of doctors. These physician's assistants would have greater capabilities and growth potential than informally trained technicians.

SEMINARS WILL BE HELD on this subject during the Annual Scientific Session in Grand Rapids on Wednesday, September 27, from 8:45 to 10:00 am and on Thursday, September 28, from 10:45 to 12:00 noon. Participating in the seminars will be Don Marshall, M.D., Kalamazoo, Chairman, MSMS Education Liaison Committee; William C. Birch, M.D., Kalamazoo, member of MSMS Study Committee on Paramedical Education and author of Resolution 2 adopted by the MSMS House of Delegates in 1965; Robert Kinsinger, Ph.D., Kellogg Foundation and a recent member of a federal study commission on manpower shortages in the health fields.

The MSMS Study Committee has reported that a plan is feasible in Michigan that such an individual (a physician's assistant) would be used by certain physicians, that they would generally be used in the hospital community, and that some would become proficient assistants in the various specialties. The Study Committee arranged the Annual Session Seminars to ask Michigan physicians for their opinions and for their help in formulating a job description. The panel will develop and present the information in some detail at the seminars.

WE NEED YOUR discussion and ideas about the program.

Similar programs are being proposed in other areas and other states, but Michigan is the only state developing a program sponsored (we hope) by its state medical society.

Medicare, Medicaid Officials to Hold "Curbstone Talks"

Officials from the Michigan agencies operating Medicare and Medicaid will open themselves to questions, complaints, or compliments from the physicians attending the MSMS Annual Session.

On Wednesday morning, September 27 from 8:45 until noon, representatives of the State Departments of Health and Social Welfare, the Social Security Regional Office, Blue Cross and Blue Shield will be present to discuss problems with individual physicians.

No formal papers will be given. Emphasis will be on personal assistance to doctors.

The Program Committee developed these "Curbstone Conferences." J. K. Altland, M.D., coordinator of the sessions, is implementing them.

A Building Block approach to treating hypertension

ABBOTT

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .

Pargyline Hydrochloride
Deserpidine
Methyclothiazide
240
220
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Consider starting your hypertensives on this basic thiazide

ABBOTT

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

ENDURON
ENDURON
METHYCLO THIAZIDE
Methyclothiazide

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE				
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

ABBOTT

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!

ENDURONYL FORTE
Deserpidine
Methyclothiazide

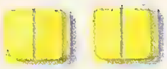
Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	 2.5 mg. methyclothiazide 0.125 mg. deserpidine	 5 mg. methyclothiazide 0.25 mg. deserpidine	 7.5 mg. methyclothiazide 0.375 mg. deserpidine	 10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	 2.5 mg. methyclothiazide 0.25 mg. deserpidine	 5 mg. methyclothiazide 0.5 mg. deserpidine	 7.5 mg. methyclothiazide 0.75 mg. deserpidine	 10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

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Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®

PARGYLINE HYDROCHLORIDE

EUTONYL®
PARGYLINE HYDROCHLORIDE
EUTONYL®
25 PARGYLINE HYDROCHLORIDE
EUTONYL®
50 PARGYLINE HYDROCHLORIDE
Pargyline Hydrochloride

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

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1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.

EUTRON
Methyclothiazide
Pargyline Hydrochloride

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE				
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

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ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R

ABBOTT

Port Huron Doctor, WSU Will Observe Centennials in '68

Wayne State University's oldest alumnus will celebrate his centennial along with his alma mater's in 1968.

Duncan J. McColl, M.D., Port Huron, and Wayne State will begin their 100th year this fall. Doctor McColl will be 99 on November 24, and WSU will begin its centennial observance with the opening of classes in September.

Doctor McColl traces his association with the school back to 1888 when he enrolled for three years of medical education at a total tuition cost of $125. The young McColl taught school in Elgin County, Ontario, and decided that the top salary of $450 per year was not sufficient income if he were to marry the young lady he fancied at the time.

HE SET OFF FOR Ann Arbor to enroll in the medical school there and stopped to visit a cousin in Detroit. The city health officer showed him the facilities of the Detroit College of Medicine at St. Antoine and Catherine Streets, and he paid his tuition.

Mr. McColl returned to teaching for a year and meanwhile was tutored in preparation for his medical schooling at the forerunner of Wayne State University.

The Detroit of 1889 was a place where a young student could find a room for $1 per week, could buy a doughnut and coffee breakfast for a nickel, and could have lunch at Wood's Restaurant on Woodward Avenue for a quarter.

Doctor McColl remembers that the trolley line only ran three miles, and you needed a strong horse to get you through the mud if you planned to go further than that on Woodward Avenue.

Medical training was somewhat different from today's modern schooling at the Wayne State School of Medicine. Doctor McColl remembers bringing home the head and arm of a cadaver to do some anatomy study. He placed the arm in the icehouse to preserve it, and a neighbor's dog pilfered it. The arm wound up on a lawn in the neighborhood. It took a considerable amount of explanation, Doctor McColl recalls, before he could convince police that a foul act had not been committed.

THE GERM THEORY OF disease was still comparatively new at the time that Doctor McColl was taking instruction. He says there was no course in bacteriology, and he recalls watching an operation in the old St. Mary's Hospital amphitheater in which a visiting surgeon from Ann Arbor performed an abdominal operation after merely rinsing his hands off.

Watched Operations at Hospitals

St. Mary's provided a place for medical students to observe operations, and nearby Harper Hospital offered an opportunity for students to get some practical experience at minor surgery.

Doctor McColl remembers the first of more than 8,000 babies that he delivered during his career. He sometimes went on evening rounds with Doctor Isaac Bentley, at whose house he roomed. On one call to an expectant mother, Doctor Bentley

(Continued on Page 1184)

Duncan J. McColl, M.D., looks at a picture of the Detroit College of Medicine, where he was a student 75 years ago. Both Dr. McColl and Wayne State University were born in 1868. They will celebrate their centennial years together. Dr. McColl also is Wayne's oldest alumnus.

Sustained circulatory, respirator and cerebral stimulation for th

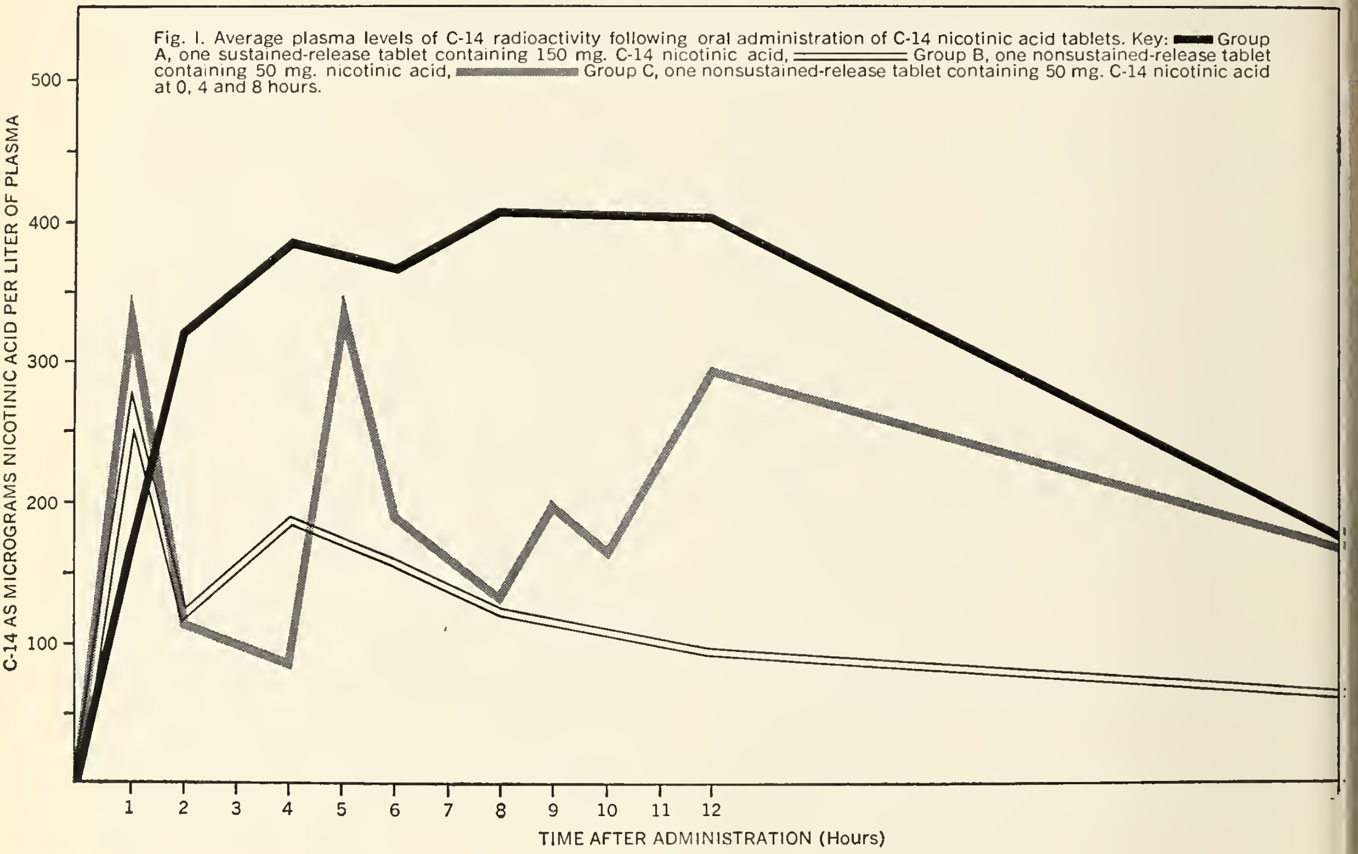

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▒ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazo TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation an with a minimum amount (if any) of "flushing." Also cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate signs of senile confusion. Patients become more alert

ged and debilitated

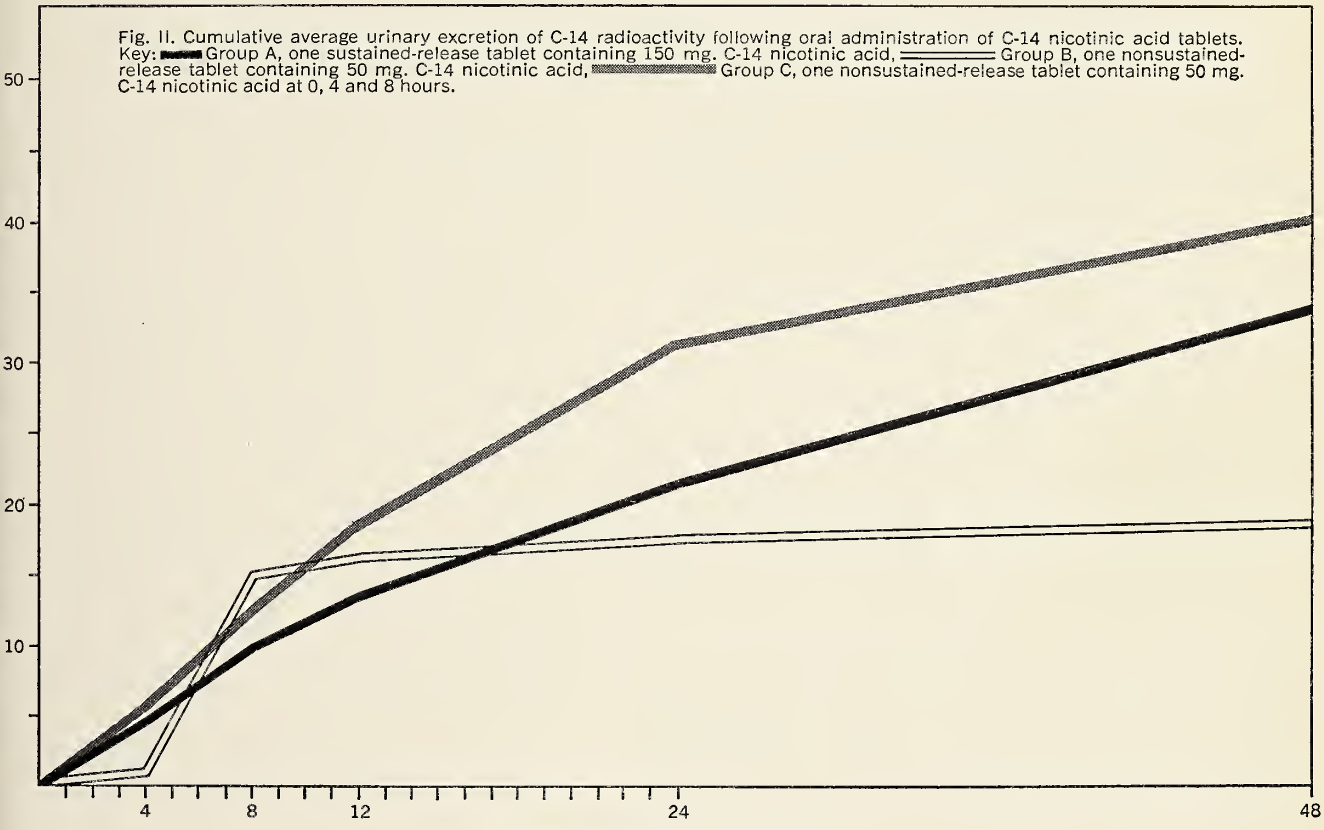

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ess confused and moody. Personal care, memory, motional stability, social attention improve. Fatigue, pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

ontraindications: There are no known contraindica-ions.

recautions: Exercise caution when treating patients vith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

left the young student with the mother-to-be and a paralyzed father with assurances that the baby would not arrive until he had visited another patient.

Shortly after Doctor Bentley left, the baby began its arrival, and the young student, without aid, handled the delivery.

ONE OF THE OLD FORMS of medical training was the preceptorship, in which young men acted as servants of doctors and studied under their guidance. During 1892 Doctor McColl supplemented his formal schooling with a period of preceptorship in the office of Doctor C. G. Jennings of Detroit. He graduated in 1893. The Doctor, who says Sundays as a student were spent at a girlfriend's house dining upon a traditional chicken dinner, was married several years after he left the College of Medicine to the former Helen Marr Clark.

Went to Port Huron in 1914

Doctor McColl practiced in Elkton, Crosswell, and Milwaukee before moving to Port Huron in 1914. In the next 50 years he delivered a good share of the population of Port Huron, in some cases three generations of the same family. More than 7,000 children were delivered by the doctor in the 25 years of his peak activity.

In 1954 his efforts were recognized when Doctor McColl was named "Michigan's Foremost Family Physician" by the Michigan Medical Society. He has enjoyed many other honors during his long career. On the mantle at the home he shares with his daughter, Mrs. Helen Alexander, is a highly-prized picture of himself with Detroit Tiger star outfielder Al Kaline.

DOCTOR McCOLL REMEMBERS his impressions of many of the innovations of the past century. "I remember the first time I saw women without bustles. We took three girls from Chatham on a boat trip to Put-In-Bay. They weren't wearing bustles and I was shocked."

The Doctor remembers seeing his first automobile when he was practicing in Elkton in 1902. It was a two-cylinder Jackson which had been purchased by a livery stable owner. The second auto in town was bought by the doctor himself.

Recalls First Car in 1902

He went to Vassar and there examined a single-cylinder Cadillac capable of speeds up to 18 miles per hour. He spent a half hour being taught how to drive the car on the fairgrounds at Vassar and then drove it home to Elkton. He remembers that he had to stop the car and stand by it, as the la required, each time a horse-drawn vehicle passe

Doctor McColl's wife died in 1934. The coupl had three children. Besides Mrs. Alexander, ther were two sons, Duncan J. McColl, Jr., an attorne who died in 1953, and Clarke M. McColl, M.D who is now retired after many years on the sta at Henry Ford Hospital. Mrs. Alexander receive her master's degree in education from Wayn State just 50 years after her father received h medical degree.

Doctor McColl doesn't hear or see as well as h once did, but he is able to walk with the aid a walker and he extends a firm hand to visitor

International Health Committee to Confer With Interested Doctors

Physicians who have been considering the ide of taking short term assignments for foreign medical work will have the opportunity to discuss possibilities with members of the International Healt Committee during the Annual Session in Gran Rapids on the afternoon of Wednesday, Septembe 27.

Members of the Committee will be availabl from 2:00 to 5:00 PM in one of the large suite of the Pantlind. The suite number will be poste on the bulletin board during the Annual Session

UP TO THE INDIVIDUAL

"It is our responsibility to increase our politica efforts in the future. At the present time we hav a weak voice in government, and I don't believ this will change until we *individually* become mor concerned and thereby know and help our representatives in all levels of government. It is stil very important to contribute financially to the candidates and party of your choice on a regular basis

"MDPAC is an excellent medium for this — the distribute money both nationally and in this stat to candidates of both parties."

Charles M. Ebner, M.D.
Past President
Macomb County Medical Societ

ew Children's ospital Going p in Detroit

Ground was broken August 8 r a new 320-bed Children's Hos- tal at the new Detroit Medical nter.

The six-story hospital, which is pected to cost $20 million, will a teaching and research institu- n as well as the pediatrics cen- r for all the hospitals in the edical Center. All of the beds ill be available for pediatric aching to the Wayne State Uni- rsity third-year medical students.

Established in 1886 as a 27-bed cility in a rented ward in Harp- Hospital, Children's Hospital w can accommodate 215 pa- ents, the present hospital will be rn down.

Paul V. Wooley, Jr., M.D., airman of pediatrics at Chil- en's observed that besides the obvious advantage in being able to teach more medical students in better facilities, the student's training will be enhanced by dealing with a larger number of patients with different diseases. This will widen his medical experience.

When a Department of Health, Education, and Welfare grant of $3.6 million was announced in February for construction of the new hospital, W.S.U. President William R. Keast said, "I am delighted at the news of the grant to assist in the construction of the new hospital. It signalizes a solid step forward in both the development of the Detroit Medical Center and in the planned expansion of the University's School of Medicine."

Another $5 million has been pledged by the United Foundation, along with roughly $5 million in the hospital's building program. Another smaller Federal grant plus funds from private sources means that virtually all the $20 million dollars needed for the building has been raised, according to Dr. Hullerman.

DOCTORS INVITED TO STATE WOMAN'S AUXILIARY LUNCH

Win Schuler, President of Schuler Restaurants, Inc., will be the luncheon speaker on Thursday, September 28, in the Kent State Room of the Pantlind Hotel during the Annual Convention of the Woman's Auxiliary in Grand Rapids.

For full details of the Annual Meeting, to be held September 26-28, see the September issue of *Michigan Medicine.*

Physicians and their wives are invited to hear Mr. Schuler's talk which, as always, will be sprinkled with wit and wisdom.

Increase Practice Control Through MANAGEMENT By

Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

OBJECTIVES

- More Time for Patient
- More Time for Leisure
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- Identify Business Problems
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"Michigan Medicine" Article Selected for Book

Once again an article that appeared in *Michigan Medicine* has been selected for inclusion in a medical book.

The U.S. Department of Health, Education and Welfare has been given permission by MSMS to reprint an article by R. E. Litman, M.D., about "Emergency Response to Potential Suicide" which appeared in January, 1963. The book will be entitled, "The Psychology of Suicide" and will be one of the Schneidman-Litman-Farberow Reader series. Publication is scheduled for 1968.

Two other articles also have been selected from among the best materials on the topics of suicide and suicide prevention.

Personal Responsibility

Excerpted from Report of
AMA President Milford O. Rouse
To 1967 AMA House of Delegates

One important aspect of civic and political activity for the individual physician should be willing and active support of the aggressive and productive work of AMPAC and of the political action committees at state and county levels. AMPAC, as you are well aware, was created by this House of Delegates; yet it still lacks support by some of medicine's leaders.

"As today's leaders of organized medicine in the United States, who created the AMPAC organization structure in order to support and disseminate the political philosophy that is held by American medicine and its many friends, we certainly should not be satisfied with anything less than 100% membership and participation in AMPAC and the other PAC organizations.

"I hope each one of us will accept that as a personal responsibility for the coming year."

FROM CONGRESSMEN:

Following are some excerpts from newsletters sent by Michigan lawmakers in Washington to their constituents:

Congressman Elford (Al) Cederberg: "Time and again requests for local and state tax increases are turned down by the voters. There appears, however, to be little concern when spending and tax increases are made at the federal level. Washington seems so far away, but remember, it is only as far away as your pocketbook. I have always felt that local and state tax dollars produce more results than federal tax dollars."

Senator Phillip Hart: ". . . I believe a damper on industrial concentration is a prudent long-range course — even from a business point of view.

"Because as competition fades as a force for lower prices, it will almost certainly be replaced by government wage and price controls. And I find this a very disagreeable prospect."

* Reported Measles Cases in Michigan

Year	1966	1965	1964	1963	1962
Total for Year	15,251	28,132	30,897	48,752	25,303
January	1,655	2,304	1,356	4,502	1,553
February	1,806	3,435	2,900	5,751	2,306
March	2,393	5,387	3,932	6,650	2,689
April	1,818	5,144	7,036	8,619	3,604
May	2,264	5,025	7,501	12,290	5,348
June	2,930	3,471	4,865	7,014	3,773
July	1,001	1,073	1,052	1,953	1,830
August	449	408	201	564	709
September	201	197	108	241	364
October	167	272	235	271	629
November	240	412	458	314	967
December	327	1,004	1,253	583	1,531

* These figures are made available to **Michigan Medicine** by George H. Agate, M.D., Chief, Division of Epidemiology, State Department of Public Health.

A Question,Doctor:

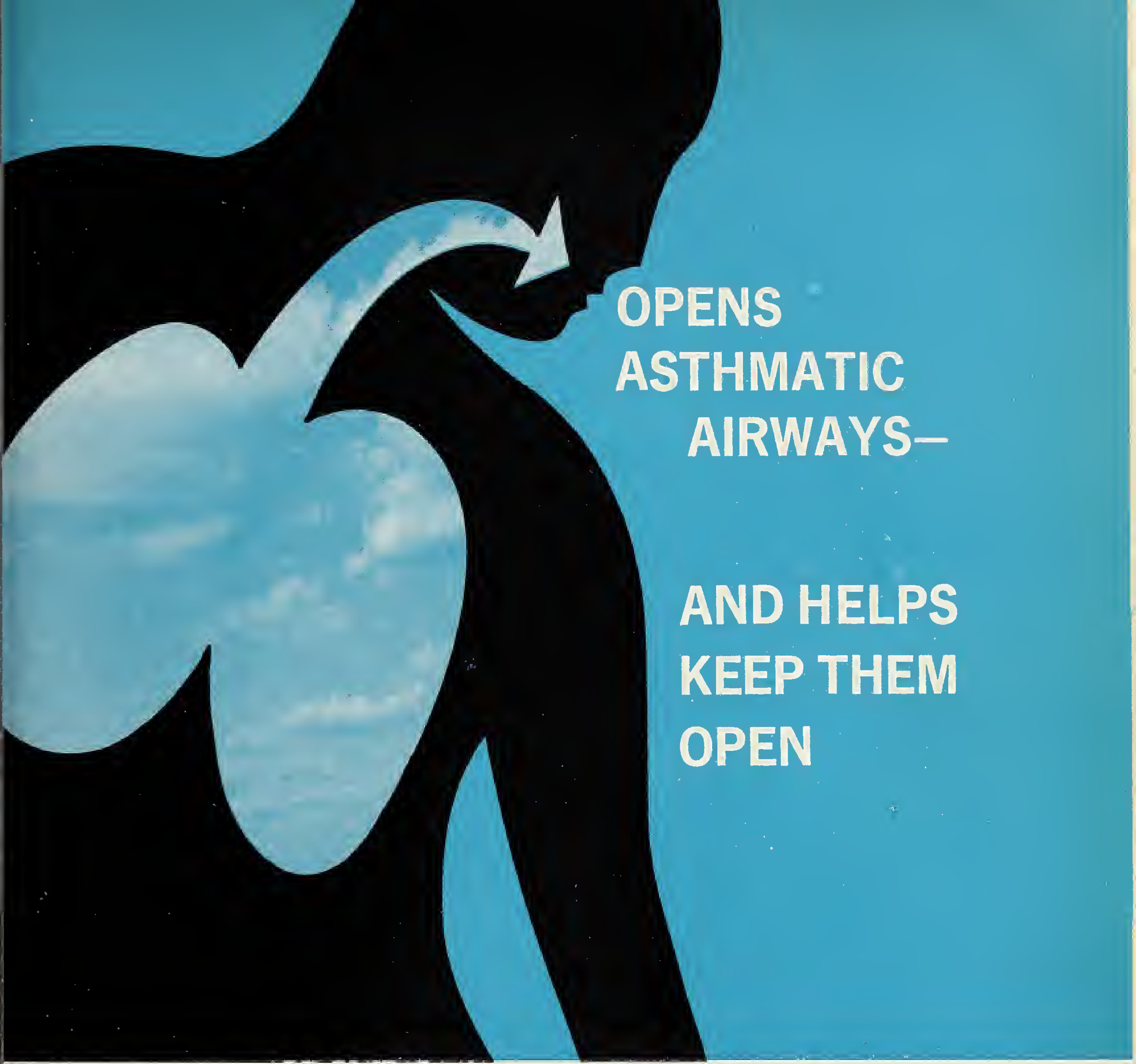
QUESTION: Is it ethical to have another doctor perform surgery on my patient without patient's knowledge and consent?

ANSWER: No. The Principles in Section 2 state that the principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. To have another physician operate on one's patient without that patient's consent, and without his knowledge of the substitution, is a fraud and deceit and a violation of a basic ethical concept. The patient as a human being is entitled to choose his own physician, and he should be permitted to acquiesce in or refuse to accept the substitution.

(Note: The AMA Law Department has prepared a statement on this subject for interested doctors.)

HALL ARTICLE EXCERPTED

The June, 1967 issue of *The Reporter,* a monthly publication of the Medical Service of D.C., in Washington, digests "The Future of Health Insurance Prepayment and Medicine, a View of 1968," an article by Charles P. Hall, Jr., Ph.D., of Philadelphia, which was printed in the January, 1967, issue of *Michigan Medicine. The Reporter* is sent to physicians who participate in the Blue Shield plan in the Washington metropolitan area.



NUMA® **DURA-TABS**®
for *prolonged* aid to ventilation

Each Numa Dura-Tab provides:

theophylline	225 mg.
ephedrine HCl	50 mg.
butabarbital	25 mg.

(Warning: butabarbital may be habit-forming.)

Numa Dura-Tabs provide *prolonged* three-way action to ease breathing. Theophylline, a potent bronchodilator with minimal effect on the CNS, opens air passages and reduces bronchial spasm. Ephedrine HCl improves breathing capacity through its decongestant action. Butabarbital, a mild sedative, allays fear and apprehension.

Dosage: One Numa Dura-Tab every 8 to 12 hours helps keep the asthmatic patient symptom-free all day/all night.

Precautions: Use with caution in cardiovascular or hyperthyroid disease, severe hypertension, circulatory collapse, prostatic hypertrophy, or glaucoma.

WYNN Pharmaceuticals, Inc. Phila., Pa. 19132 ● Manufacturers of QUINAGLUTE® DURA-TABS®
(QUINIDINE GLUCONATE 5 gr.)

67.9 of WSU Grads in Michigan

"A detailed study of our graduates shows that 67.9 per cent of the Wayne State University medical alumni are now practicing in Michigan."

So reports WSU Dean Ernest Gardner, M.D. He said that "While our graduates sometimes prefer to intern in hospitals outside of Michigan, a large percentage return to Michigan for their practice of medicine."

Offer the Latest Information about Rubella Testing

The following information about "Rubella Testing" is presented to MSMS members by the MSMS Committee on Child Welfare and the Michigan Department of Public Health:

"The laboratory diagnosis of rubella requires that patients' sera be submitted for antibody titration and, in some instances, throat swabs for attempted virus isolation. Swabs must reach the laboratory within a few hours and must be kept iced during transit. Upon request, Dr. Maurice Becker, telephone 373-1426, Chief, Virology Section, will supply a special kit for the submission of throat swabs for isolation of virus.

"Neither the Michigan Department of Public Health nor the U.S. Public Health Service Communicable Disease Center is equipped to perform tests on specimens from routine uncomplicated illness. However, specimens will be accepted from those cases which meet the following criteria:

"1) Determination of immune status of women in the first trimester of pregnancy. Submit one serum specimen, taken within a few days following exposure.

"2) Confirmation of rubella infection in pregnant women (first trimester). Two serum specimens are required, one taken during early acute stage and a second taken 10 days to two weeks later. It is also suggested that a throat swab, taken within the first three days of illness, be submitted for virus isolation.

"3) Determination of antibody titer in very young children with possible rubella syndrome. Rubella antibody titers on sera of children between the ages of 6 months and 5 years would be especially meaningful because children of this age have lost most of their transplacentally acquired antibody. Virus isolation from throat swabs of babies with anomalies is also recommended. Virus may be shed for over a year in babies with anomalies.

"4) Patients with presumptive complication of rubella. Both sera and throat swabs should be submitted.

VA CARE PROGRAM PROCEDURE SIMPLIFIED

A new procedure effective July 1, 1967 has recently been announced by the Veterans Administration which should simplify the administration of the fee program. Each service-connected veteran receiving fee basis, out-patient treatment will be provided an identification card, and an announcement of this new procedure is being sent by the VA to all participating physicians. VA has stated categorically that "Rates will be generally consistent with the usual and customary fees," and MSMS has every confidence that a serious dislocation will not occur.

Since July 1, 1967, no formal agreement has existed between MSMS and the VA for reimbursement to Michigan physicians who are participating in the VA Hometown Care Program. Although the VA has acknowledged MSMS' desire to utilize the 1965 MRVS (revised 1966) as a guideline, long-range federal budgetary allocations prevented the full acceptance of the MRVS, including codes and nomenclatures.

The MSMS Council recently approved a recommendation of the MSMS Committee on Governmental Medical Care Programs stating that "In the future, payment from all governmental agencies be on the same basis as in Title XVIII B — Medicare."

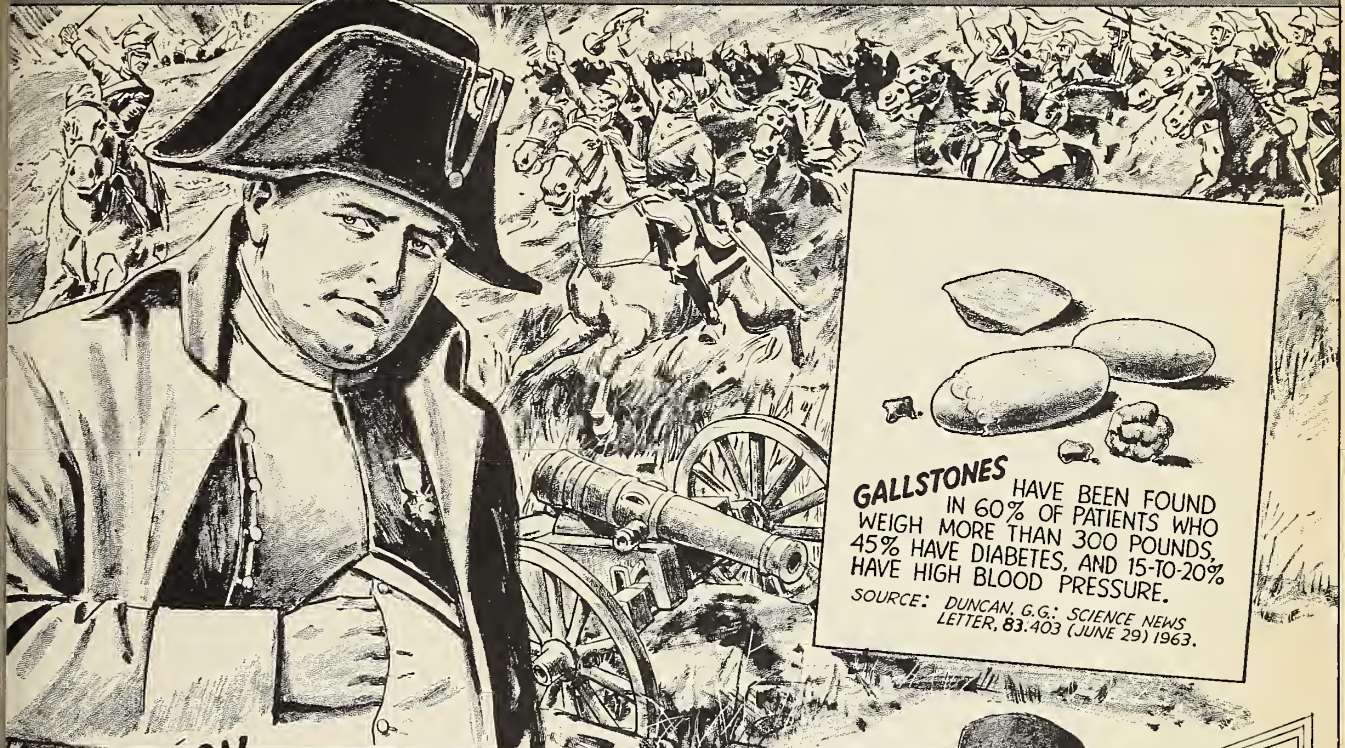
This action came as a result of the Committee's feeling that, since the federal government has adopted the policy of reimbursing physicians for services in both Medicare and Medicaid on the basis of the physician's usual, customary, and reasonable charges, there should be no delineation of physicians' reimbursements that differs from that principle. MSMS has constantly urged physicians to use the MRVS as a guideline only, stressing that the physician is the sole judge in the determination of his fees.

The VA acknowledged that MSMS' position was understandable, though the VA could not agree to this principle at the present time.

In several states the fee program seems to be operating successfully in the absence of an accepted fee schedule between the State Medical Society and the VA.

The AMBAR SCRAPBOOK of Obesity Oddities

FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLÉON BONAPARTE *LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!*

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.

THE BOOK ***"PRAY YOUR WEIGHT AWAY"*** URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.

ICE CREAM PARLOR

DIET DROPOUTS ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY.**

**SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).*

ONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

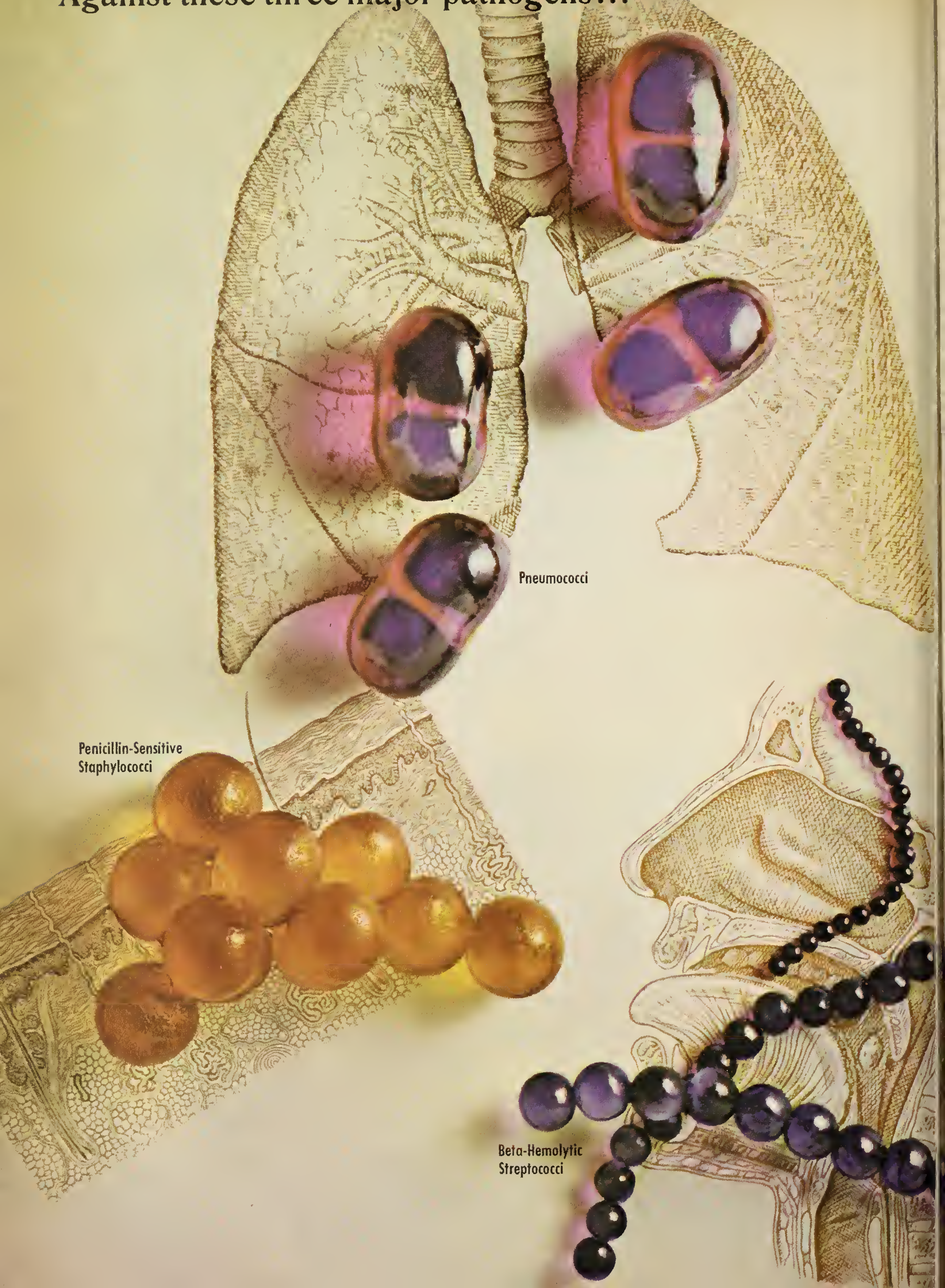
ne Ambar Extentab before breakfast can
elp control most patients' appetite for up
12 hours. Methamphetamine, the appe-
te suppressant, gently elevates mood and
elps overcome dieting frustrations. Pheno-
arbital, the sedative in Ambar, controls irritability and
nxiety...helps maintain a state of mental calm and equa-
imity. Both work together to ease the tensions that erode
e willpower during periods of dieting.
lso available: Ambar #1 Extentabs®—methamphetamine
ydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warn-
g: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H-ROBINS

Against these three major pathogens...



Pneumococci
Penicillin-Sensitive Staphylococci
Beta-Hemolytic Streptococci

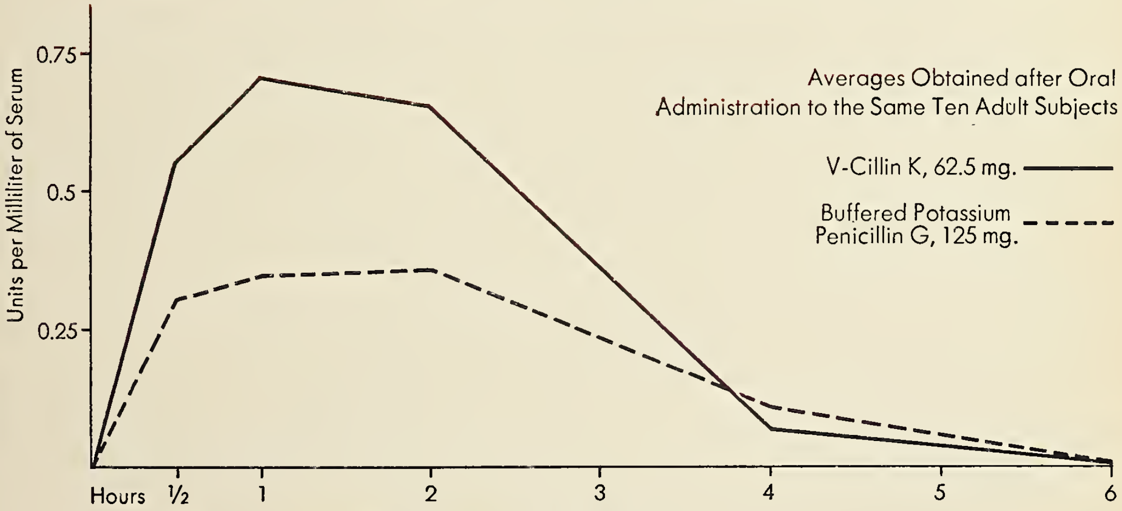
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Block, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700867

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information

100
TABLETS No. 1832
V-CILLIN K®
POTASSIUM PHENOXYMETHYL PENICILLIN TABLETS, U.S.P.
500 mg. (800,000 Units)
DATED
Lilly

New 500 mg. tablets...a more convenient way to give high doses

Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenitol heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with h parenteral dosage schedules, frequent evaluation of the renal c hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory stud (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth pencillin-insensitive organisms. In such cases, its administration sho be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much l common with administration of oral penicillin than with intramuscu forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sigr cant index of sensitization. The following hypersensitivity reactic associated with the use of penicillin have been reported: skin rasl ranging from maculopapular eruptions to exfoliative dermatitis; u caria; and reactions resembling serum sickness, including chills, fev edema, arthralgia, and prostration. Severe and often fatal anaphylc has occurred (see Warnings). Hemolytic anemia, leukopenia, thrc bocytopenia, and nephropathy are rarely observed side-effects c are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin Pediatric, the usual dosage ranges from 125 mg. (200,000 units) thi times a day to 500 mg. (800,000 units) every four hours. For infor the daily dosage may be 50 mg. per Kg. of body weight divided i three doses.

Beta-hemolytic streptococcus infections without associated b teremia may be treated with 200,000 to 400,0000 units three time day. Therapy should be continued for a minimum of ten days to prev development of rheumatic fever and/or other serious complicatio Dosage for routine streptococcus prophylaxis in patients with a histc of rheumatic fever or congenital heart disease may be 200,000 ur once or twice daily. When such patients undergo tonsillectomy, toc extraction, or other minor surgery, the prophylactic dose should 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible on the c of surgery, parenteral therapy should be considered. Mild to mod ately severe pneumococcus pneumonia has been treated effectiv with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be giv every six to eight hours in conjunction with indicated surgical pro dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours three doses may be employed; in females, 500 mg. every four ho for six doses are recommended. Refractory infections generally respo to a second treatment three to four days following completion of first. Treatment of gonorrhea with severe complications should individualized, with prolonged and intensive treatment. Patients wit suspected lesion of syphilis should have a dark-field examination l fore receiving penicillin and monthly serologic tests for a minimum three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 n (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) p 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [0320

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

700

about doctors and their friends

Alfred B. Swanson, m.d., Grand Rapids, is new chairman of the Health and Medical Education Committee of the Michigan Partners of the Alliance. Hugh W. Brenneman, MSMS Executive Director, preceded Doctor Swanson in his position, but Mr. Brenneman is now chairman of the Committee of the Professions of the Partners of the Alliance.

Two Ann Arbor physicians will speak at the athletic conference that will be a part of the AMA Convention in Houston, November 26. Richard C. Schneider, m.d., will speak on "Decisions Concerning Concussions," and Robert E. Anderson, m.d., will discuss "Genitourinary Tract Injuries." Doctor Schneider is a member of the AMA Committee on the Medical Aspects of Sports.

Verne L. Hoshal, Jr., m.d., Durand, was awarded a Bronze Star for rendering medical treatment to the Vietnamese people during his military service. Doctor Hoshal is now serving a residency in surgery at St. Joseph Hospital, Ann Arbor.

A grant of $84,152 has been awarded to Gordon C. Brown, m.d., Ann Arbor, by the National Foundation — March of Dimes. Doctor Brown is tracking down maternal virus infections that kill or cripple unborn children. He already has shown that babies whose mothers were infected with a Coxsackie B. Virus during pregnancy are more likely than other children to suffer from congenital heart disease.

Robert D. Parkhurst, m.d., First-Year Resident in Pediatrics at University Hospital, Ann Arbor, is the recipient of a residency fellowship in pediatrics sponsored by the Wyeth Fund. Doctor Parkhurst is one of 15 recipients of the $4,800, two-year award for advanced study in child medicine.

Paul Lowinger, m.d., Detroit, presented a paper on "Therapist Bias in the Selection and Treatment of Patients" at the International Congress of Psychotherapy, August 21-26. While in Europe, Doctor Lowinger also gave lectures to the Norwegian Psychiatric Association in Oslo, the Department of Psychiatry of the Medical School in Sofia, Bulgaria, the Institute for Psychotherapy in Munich, and the Institute for Criminals in Denmark.

Serving now on the council of the Radiological Society of North America as Michigan's representative is Emil Shebesta, m.d., Muskegon.

Ames Robey, m.d., former Medical Director of the Massachusetts Correctional Institution at Bridgewater State Hospital, has been named director of the Michigan Department of Mental Health's new Center for Forensic Psychiatry, temporarily located at Ypsilanti State Hospital. Doctor Robey will be assisted by Curtis W. Davis in working to diagnose and evaluate patients committed to the Department by criminal courts.

Four Gratiot Community Hospital physicians were honored recently at a dinner in Alma, one of them posthumously. The posthumous award was for the late Clarence Hoogerland, m.d., of Alma, and was accepted by his wife, Mrs. Virginia Hoogerland. The other three physicians, who either have retired or are about to do so, to receive an award were C. B. Wood, m.d., of Mt. Pleasant, Melvin J. Budge, m.d., of Ithaca and Alma, and Donald K. Barstow, m.d., of St. Louis.

Joseph Johnston, m.d., Ford Hospital, was reelected a director of the Friends of the Detroit Public Library. This is Doctor Johnston's second, three-year term in this capacity.

A Michigan State University professor of Natural Science, Oscar Taboada, ph.d., was awarded a Certificate of Merit from the Navy's Bureau of Medicine and Surgery for his work in rewriting the Medical Entomology Manual used by the United States Navy Medical Department.

Stefan S. Fajans, m.d., Ann Arbor, is a member of the Committee on Professional Education of the American Diabetes Association which has published a classification of genetic diabetes mellitus in the journal *Diabetes*. Doctor Fajans is also a member of the ADA's Board of Directors.

Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, EQUANIL (meprobamate) often may play an important role in medical and surgical aftercare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If an allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leucopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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SERVICE TO MEDICINE

Equanil®
(meprobamate)
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Professionally posed.

new members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Richard E. Bickham, M.D., 101 W. John Street, Bay City 48706

Carl H. Cohen, M.D., 110 Professional Building, 909 Woodward Avenue, Pontiac 48053

William T. Conner, M.D., 146 Osceola Street, Laurium 49913

Robert M. Daugherty, M.D., 599 Pebblebrook Lane, East Lansing 48823

Bertram D. Dinman, M.D., 1132 Aberdeen Drive, Ann Arbor 48104

Paul Dykema, M.D., 788 Columbia Avenue, Holland 49423

Atanasio C. Farjardo, M.D., Oakwood Hospital, Dearborn 48124

George R. Gerber, M.D., 310 W. University Drive, Rochester 48063

Nurettin B. Gokcora, M.D., Caro State Hospital, Caro 48723

Mono Gueramy, M.D., 1411 Center Avenue, Bay City 48706

Oscar M. Guillamondegui, M.D., 205 William Beaumont Medical Building, 3535 West 13 Mile Road, Royal Oak 48072

Ralph M. Hodges, M.D., 914 S. Burdick, Kalamazoo 49001

Eugene J. Kochkodan, M.D., 15520 Garfield, Allen Park 48101

William J. Kube, M.D., 1219 S. Park Street, Kalamazoo 49001

Henry J. Lukaszek, M.D., Community Hospital, South Haven 49090

Helio B. F. Martins, M.D., 714 Beach Street, Flint 48502

Franklin T. Miles, M.D., 4631 Shenandoah Avenue, Allen Park 48101

Ronald H. Nishiyama, M.D., 3009 Geddes Avenue, Ann Arbor 48104

Richard Potter, M.D., Marquette County Health Department, Marquette 49855

Wilmer M. Rutt, M.D., 310 Warwick Drive, Alma 48801

Delfin F. Santos, M.D., 18101 Oakwood, Dearborn 48124

Pedro A. Sevidal, Jr., M.D., 1018 North Avenue Battle Creek 49017

Richard L. Taylor, M.D., Emma Bixby Hospital Adrian 49221

Siavosh, Varjavandi, M.D., 3169 W. Pierson Road Flint 48504

Nicholas N. Velarde, M.D., 721 W. Sixth Avenue Flint 48503

Paul Van Den Brink, M.D., 507 Bronson Medica Center, Kalamazoo 49006

Richard K. Waeschle, M.D., 2100 Fourth Street Jackson 49203

Emile F. Wamsteker, M.D., 3415 Robinwoo Drive, Ann Arbor 48103

James Wheat, M.D., Allegan 49010

David B. Witte, M.D., Route 3, South Have 49090

William H. Woodhams, M.D., 3125 W. Main Kalamazoo 49007

Robert N. Gamble, M.D., 608 Eberwhite, An Arbor 48103

Boleslaw Pietruszka, M.D., 5210 Lapeer Road Flint 48503

James D. Van Brocklin, M.D., 2765 Flushing Road Flint 48504

A. Abbassian, M.D., 970 Fisher Building, Detroi 48202

Eduardo Arciniegas, M.D., Henry Ford Hospital Detroit 48202

Khosrow Beizai, M.D., 22101 Moross Road, Detroit 48236

Alfredo J. do Pico, M.D., 6221 Merriman Road Garden City 48135

Marie N. Fly, M.D., Oakwood Hospital, Dearbor

Aristomenis K. Kargas, M.D., Wayne County Gen Hospital, Eloise 48132

Thomas V. McManamon, M.D., Ford Motor Company, Dearborn

Jose W. Miller, M.D. Children's Hospital, Detroit 48202

Eugene P. O'Donnell, M.D., 3700 West Road Trenton 48183

Fernando N. Salazar, M.D., 2645 Grange Road Trenton 48183

Jean Sinkoff, M.D., 19105 West Seven Mile Road Detroit 48219

Charles Canty, M.D., 2347 Yost Boulevard, An Arbor 48104

Robert M. Cutler, M.D., 3178 Williamsburg Road Ann Arbor 48104

Paul H. Engle, M.D., Olivet 49076

James S. Gregory, M.D., 1441 Mayfield Avenue N.E., Grand Rapids 49505

Gerhardt A. Hein, M.D., 1121 Granger, An Arbor 48104

William M. Heston, III, M.D., 2951 Sheffiel Court, Ann Arbor 48105

(Continued on Page 1197)

FACTS/OSTEOPATHIC SCHOOLS

The Health Resources Statistics handbook for 965 gives the following statistics about *5 DO chools, all of which are rated as "private."

	Students	Graduates
Chicago College of Osteopathy	232	45
College of Osteopathic Medicine and Surgery, Des Moines	305	76
Kansas City College of Osteopathy and Surgery	403	103
Kirksville (Mo.) College of Osteopathy Surgery	380	98
Philadelphia College of Osteopathy	341	73

American Osteopathic Association, Jan. 1966.

American Osteopathic Association, Jan. 1966.

Wanted: Names of Leaders Of Medical Organizations

Michigan Medicine would like to obtain and rint a full list of the medical specialty organizaions in Michigan with the names and addresses of heir current offices.

Some of this information is on file, but the list s incomplete.

This is an appeal that the offices of the specialty groups in Michigan please provide such information today.

Please write to Managing Editor, *Michigan Medicine,* 120 West Saginaw Street, East Lansing Michigan 48823.

NEW MEMBERS/Continued

Frank V. Keary, M.D., 326 N. Ingalls, Ann Arbor 48104

Leonardo V. Lopez, M.D., 295 West Huron, Pontiac 48053

James B. Orwig, M.D., 1025 Island Drive Court, Ann Arbor 48105

Murray S. Renfrew, M.D., 311 Gralake, Ann Arbor 48103

Kathryn E. Richards, M.D., 413 Mark Hannah Place, Ann Arbor 48103

Thomas A. Smith, M.D., Detroit General Hospital, Detroit 48826

Allan H. Stephan, M.D., 1840 Stadium Place, Ann Arbor 48103

Erol Ucer, M.D., 2835 West Genesee Street, Lapeer 48446

John B. Juncker, M.D., Oakwood Hospital, Dearborn 48124

Marcelo Peisojovich, M.D., Grace Hospital, Detroit 48201

Jorge Gomez, M.D., Mc USNS, Box 15, FPO, San Francisco, Calif. 96651

Rex G. Wilcox, M.D., (Associate) 1045 Keneberry Way, S.E., Grand Rapids 49506.

David B. Youel, M.D., (Associate) Pontiac General Hosp., Pontiac 48053.

What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).........(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

book reviews

Respiratory Care Directory of Michigan Hospitals. Published by the Michigan Tuberculosis and Respiratory Disease Association, Lansing, Michigan. No charge. 1967.

This is a survey of the facilities to be found in Michigan hospitals for the diagnosis and treatment of respiratory diseases. The publishers state that over 80% of the hospitals in the state responded to a questionnaire which was used to obtain the data placed between the covers of this publication. The information is broken down by counties and further divided into facilities available and diagnostic procedures available. Under the former, one can find whether a pulmonary function laboratory or inhalation therapist or a vocational counselor or a tank respirator are to be found in a specific hospital. These examples are not all inclusive but give some indication of the coverage in this manual. Similarly there is a breakdown of the diagnostic procedures available in each hospital unit. To aid in finding this information, a different colored page is used for each of the subjects outlined. Blue is used for facilities, yellow for diagnostic procedures and pink for admission policies.

This is certainly a worthwhile manual which will provide needed information about respiratory care facilities. A copy can be obtained from the Association by communicating with them directly.

George H. Lowrey, M.D.

Handbook of Poisoning: Diagnosis and Treatment. By Robert H. Dreisbach. 5th Edition. Lange Medical Publications, Los Altos, California. 1966. $5.00.

If the reviewer's library on poisoning was limited to one book, this would be the book that he would own. This publication is a perfect example of the old cliche that good things come in small packages.

The first sentence in the author's preface deserves to be quoted. "The purpose of this handbook is to provide a concise summary of the diagnosis and treatment of clinically important poisons." This is precisely what this small book has accomplished and does so in a manner that is very convenient and easily understood. The instructions given are very clear and are often presented in tabular form. The index is excellent, facilitating finding of pertinent information. Having used previous editions of this book over a period of ten years as the director of a large poison center, the reviewer can state that it has seldom been a disappointment so far as finding the information desired. It is surprisingly comprehensive in its coverage and with this latest edition is very much up to date.

No hospital should be without a copy of this and certainly most pediatricians will find it extremely useful. Its small size and paperback construction make it extremely handy but perhaps discourages or disappoints the librarian who is impressed by the size of most medical textbooks. Although this handbook cannot be described as a fine example of the bookmaker's art, it is very sturdily put together, well printed and well organized. Author and publisher are to be congratulated for keeping this publication available and up to date.

George H. Lowrey, M.D.

The Neurologic Examination. By Russell N. DeJong. Third Edition. $29.50. Hoeber Medical Division, Harper & Row, Publishers, New York, 1967.

This is the third edition of a textbook which has become a classic in its field. Cost, size and subject matter would probably discourage most physicians from owning a copy of this excellent book. Any medical library that takes pride in the adequacy of its reference works would have a copy available. Primarily this book will be of interest to neurologists, both graduate and undergraduate, and to neurosurgeons. This book was conceived not simply as a guide to the technique of the neurologic examination but also to relate this technique to neuroanatomy and neurophysiology. My only criticism of this book is that sometimes it is difficult to find the relationship of specific neurologic abnormalities to the disease or diseases in which it may be found or related.

The subject matter is covered comprehensively. It is divided into ten sections. The first part concerns the neurologic history and the general physical examination. Also included in this section are some pertinent statements concerning the mental examination. The next seven sections take up specific systems or areas. Examples are examination of the sensory system, the cranial nerves, the reflexes and the autonomic nervous system. A very excellent chapter is entitled *Examination in States of Disordered Consciousness: Coma, Stupor, Delirium, and Convulsions.* The material covered is not easily found in other texts. The forty pages devoted to this chapter cover the subject matter very beautifully indeed. The final chapter is devoted to the technique of obtaining and examining the cerebrospinal fluid.

Although the author gives credit to a number of people for their help, it is obviously the work f one person dedicated to the exhaustive coverage of his subject. The merit of this text is not nly that it is so comprehensive but also that it is clearly written.

George H. Lowrey

he Thymus, Experimental and Clinical Studies, Ciba oundation Symposium, eds. G. E. W. Wolften-olme and Ruth Porter, Boston: Little, Brown nd Co., 1966, 938 pp. Illus. $15.

There have been few advances in medicine that ave developed as rapidly as the field of immunology and the role played by the thymus. Within period of less than ten years we have gone from condition of almost complete ignorance of the unction of the thymus to one in which our realiation of its importance is well-authenticated. This ymposium is an excellent review of that progress. ome aspects of immunology are not considered in epth because the primary purpose is to discuss he function of the thymus.

The major topics of the Symposium were the tructure and development of the thymus, the unction of the lymphcyte, the role of the thymus n cellular and humoral immunity, its role in leukemia and carcinogenesis and finally, the auto-immune diseases. All of the reviews are well-written nd edited. The discussion following the presentation of each paper is surprisingly lucid and again hows that the editing has been carefully done. The various authors point out that many problems remain to be solved. Among the most interesting of these is the origin of immune-competent cells. Included in the questions raised are: whether they originate outside the thymus or within its structure; whether they are influenced by hormones from the thymus and, if so, for how long a period in life; do individual lymphocytes and other immune-competent cells produce a single antibody, or is each cell capable of producing multiple antibodies? The problem of self-recognition and avoidance of generalized auto immunity is explained only in theory at the present time.

It would be difficult to single out any of the papers as being especially outstanding owing to the general excellence of the Symposium. Most interesting to the reviewer were the papers by Good and associates discussing the ontogenetic and phylogenetic considerations of the thymus and the final presentation on the significance of auto-immune disease by Dameshek.

Finally, as is true of all the Ciba Symposium volumes, the book is well-constructed with good print and excellent reproductions of the illustrations.

George H. Lowrey, M.D.

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in memoriam

G. D. Cummings, M.D., Dies; Widely Known For Lab Research

G. Donald Cummings, M.D., Lansing, Associate Director of the Michigan Department of Health and Director of the Department's Laboratories, died July 27. He was 62.

Associated with the Health Department for 41 years, Doctor Cummings had been director of the state health laboratories since 1944, and in 1948 he served as acting state health director.

Born in Quincy, Massachusetts, Doctor Cummings received his bachelor's degree from Massachusetts Institute of Technology, his Ph.D. in bacteriology from the University of Michigan, and his M.D. degree from Wayne State University. He served his internship at St. Lawrence Hospital in Lansing.

He was a fellow of the American College of Preventive Medicine and a member of the Lansing Medical Journal Club, the Lansing City Club, and the Lansing city library's citizen advisory committee.

Among the honors conferred on Doctor Cummings were: the Michigan Health Council Award for Outstanding Achievement, the Administration Career Service Award of the Michigan Capital Chapter of the American Society of Public Administration, the Michigan State Medical Society Certificate of Commendation, and a Certificate of Appreciation from the office of the President for his work in a national blood program. He was listed in Who's Who in America.

F. A. Adams, M.D., Grand Rapids

Frank A. Adams, M.D., 58, Grand Rapids general practitioner, died August 6.

A native of Pennsylvania, Doctor Adams was graduated from Pennsylvania State College and St. Louis University Medical School. He had practiced in Grand Rapids for the past 32 years.

During World War II, Doctor Adams served in the United States Navy in the Atlantic and Pacific theaters.

In Grand Rapids Doctor Adams was affiliated with Butterworth Hospital. He was a member of the Exchange Club, Knights of Columbus, and Alpha Kappa Kappa medical fraternity.

E. W. Dales, M.D., Grand Rapids

Ernest W. Dales, M.D., 82-year old general practitioner, died July 25. Doctor Dales practiced in Grand Rapids.

A graduate of the University of Michigan Medical School, Doctor Dales entered practice in Grand Rapids in 1908. In Grand Rapids he was affiliated with Butterworth and St. Mary's hospitals and was on the staff of Maple Grove Medical Care Facility.

Doctor Dales was a member of the Monarchs and Lions clubs as well as various medical societies.

L. H. Darling, M.D., Lansing

Lewis H. Darling, M.D., 69-year-old Lansing physician, died July 27.

Doctor Darling was graduated from Albion College and received his M.D. degree from the University of Michigan Medical School in 1921.

Affiliated with St. Lawrence and Sparrow hospitals, Doctor Darling was a member of the F. and A.M. Lodge Number 33 and of various professional organizations.

Gerald DeMaagd, M.D., Rockford

Gerald DeMaagd, M.D., Rockford, general practitioner for 37 years, died July 13. He was 62.

Doctor DeMaagd was a graduate of the University of Michigan Medical School and was a member of the American Academy of General Practice and Western Michigan Academy of General Practice.

A past president of the Rockford School Board, Doctor DeMaagd was at one time Kent County Examiner for the Selective Service.

In Grand Rapids he was affiliated with Butterworth, Blodgett, and St. Mary's hospitals, and in Greenville he was associated with United Memorial Hospital.

C. R. Gatley, M.D., Pontiac

Cleo R. Gatley, M.D., Pontiac physician and former chief of staff at Pontiac General Hospital, died July 17. He was 61.

Doctor Gatley came to Pontiac in 1931 after graduating from the Washington University Medical School.

He was a member of the American Society of Internal Medicine, the Michigan Society of In-

(Continued on Page 1203)

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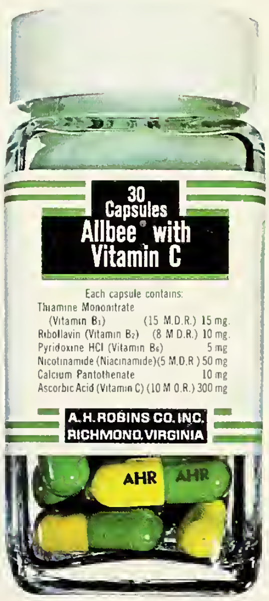
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nal Medicine and was a Fellow of the Ameri- n College of Physicians. His fraternities were pha Kappa and Delta Upsilon.

uring World War II Doctor Gatley served as aptain in the United States Air Force.

L. Hagman, M.D., Oregon

George L. Hagman, M.D., Medford, Oregon, fe Member of the Michigan State Medical So- ty, died May 28 at the age of 81.

A graduate of Stanford University Medical hool, Doctor Hagman specialized in orthopedic gery.

From 1914 to 1938 Doctor Hagman served as a dical missionary at Nantung Ku. Christian Hos- al, China. From 1942 to 1946 he was affiliated th New York Orthopedic Hospital and later was ociated with Cranbrook Infirmary, Bloomfield lls, General and St. Joseph Mercy hospitals in ntiac, and Beaumont Hospital in Royal Oak. Doctor Hagman was a fellow of the American llege of Surgeons and of the American Board Orthopedic Surgery.

arold Henderson, M.D., Detroit

Harold Henderson, M.D., longtime Detroit phy- ian, died August 8 at the age of 74.

A Life Member of the Michigan State Medical ciety, Doctor Henderson was a graduate of the niversity of Michigan Medical School. He was a mer member of the staffs of Providence and rper hospitals and was a clinical professor at ayne State University until three years ago.

Doctor Henderson was a member of the Detroit hletic Club and the Detroit Golf Club. Profes- nal affiliations included the Central Association Obstetricians, the American Association of Ab- minal Surgeons, the American Board of Obste- cians and Gynecologists, and the American Col- ge of Surgeons.

. B. Keeler, M.D., Albion

Kenneth B. Keeler, M.D., retired Albion phy- ian, died July 15. He was 72.

Doctor Keeler was graduated from Northwestern niversity Medical School in 1918 and served his ternship at Cook County Hospital in Chicago.

Active in many organizations, Doctor Keeler was past president of the Calhoun County Medical ciety and at one time served as Albion Public Schools physician, city health officer, and examining physician for the Calhoun County Selective Service Board. In addition, Doctor Keeler served on the boards of the Calhoun County Tuberculosis Association and the Calhoun County Cancer Society.

He was a Life Member of Concord Lodge No. 30, F. and A.M., and a former member of the Patrick Leo Hanlon Post No. 44, American Legion, and of Rotary International.

Doctor Keeler was affiliated with Sheldon Memorial Hospital.

J. S. Lambie, M.D., Birmingham

John S. Lambie, M.D., Birmingham, Past President, Secretary, and Editor for the Oakland County Medical Society, died June 25. He was 85.

Doctor Lambie was graduated from Jefferson Medical College in Philadelphia in 1906. Shortly after his graduation he entered the United States Army for 16 years of service. During that time he was commander of Base Hospital 38, and later he was awarded the French Legion of Honor for his service during World War I.

In 1927 Doctor Lambie moved to Pontiac where he was plant physician for the Fisher Body Company. In 1949 he retired from that position and became deputy director of the South Oakland office of the Oakland County Health Department. In 1954 he became Oakland County health program coordinator.

A Life Member of the Michigan State Medical Society, the Oakland County Medical Society, and the Industrial Medical Association, Doctor Lambie was also a member of the American Public Health Association, the Industrial Medical Association, and Alpha Omega Alpha and Phi Beta Pi medical fraternities. He was a former member of the Optimist and Torch organizations.

R. J. McGillicuddy, M.D., Lansing

Robert J. McGillicuddy, M.D., Lansing pediatrician, died July 27. He was 58.

A graduate of the University of Michigan, Doctor McGillicuddy was affiliated with Sparrow and St. Lawrence hospitals in Lansing.

During World War II Doctor McGillicuddy served in the United States Army Medical Corps as a major.

He was a member of the American Academy of Pediatricians, Michigan State University Varsity Club, and Rotary International.

Doctor McGillicuddy was the brother of Oliver B. McGillicuddy, M.D., Lansing.

(Continued on Page 1204)

A. L. Richardson, M.D., Detroit

Allan L. Richardson, M.D., Detroit pediatrician for more than 40 years, died July 27 at the age of 82.

Doctor Richardson received his medical degree from the University of Michigan Medical School and did graduate work at Harvard University.

A past president of the Detroit Pediatric Society, Doctor Richardson was also a former head of the Pediatrics Department of Children's Hospital, Detroit.

Doctor Richardson was a member of Nu Sigma Nu medical fraternity, the Exchange Club, and he was a charter member of the American Academy of Pediatrics.

R. D. Scott, M.D., Flint

Robert D. Scott, M.D., Flint, a practicing ph sician for 56 years, died July 10 at the age of 7

A native of Flint, Doctor Scott was a Life Mer ber of the Michigan State Medical Society, and i 1961 was awarded a 50-Year Pin. In 1936 l served as president of the Genessee County Med cal Society and was its treasurer in 1930.

Doctor Scott was graduated from the Detro College of Medicine in 1911. He did postgradua work at St. Mary's Hospital, Detroit, and pra ticed in Rudyard from 1914 to 1917.

Doctor Scott returned to Flint in 1920 aft serving in World War I.

He was a member of the Amercian Academy (General Practice and of the Flint Elks Lodge 22

Course in Psychiatry For Non-Psychiatrists Offered in 7 Cities

A course in psychiatry, geared to the non-psychiatric physicians, will be given in seven Michigan cities this fall. The pattern is to meet one day a month for nine months, September through May. The faculty are qualified members of the Michigan Society of Psychiatry and Neurology and the Michigan District Branch of the American Psychiatric Association.

The 1966-67 postgraduate seminars dealt with Marital Dynamics and Family Therapy and were completed this summer.

The 1967-68 postgraduate seminars in psychiatry, "The Physician as an Acute Emergency Psychiatrist," will emphasize the Techniques of Crisis Intervention, Community Mental Health and Psychiatry, and Relevant Diagnostic and Therapeutic Techniques to integrate the efforts of all physicians with all paramedical people who work with disturbed or upset patients.

Physicians interested in enrolling should contact: Leonard Rosenzweig, M.D., 515 Lakeside Drive, S.E., Grand Rapids, Michigan 49506; Telephone: GL 1-0738; or your local coordinator.

The local coordinators are:

Ferndale — Sidney Bolter, M.D., Clinical Director, Kingswood Sanitarium, KE 5-4300.

Flint — John T. Manwaring, M.D., 1654 Seminole Street, CE 9-7861.

Grand Rapids — Leonard Rosenzweig, M.D., 515 Lakeside Drive, S.E., GL 1-0738.

Kalamazoo — Cyril Curran, M.D., Borgess Ho pital, 349-1581, and W. R. Slenger, M.D., 508 Vi lage Street, 345-8862.

Jackson — Warren S. Wille, M.D., 5325 Brow Lake Road, ST 4-0440.

Lansing — H. C. Tien, M.D., 701 North Loga Street, 372-4660, and Jose J. Llinas, M.D., 40 West Greenlawn, 484-2511 Ext. 204.

Saginaw — Victor Kershul, M.D., 120 Nort Michigan Avenue, 793-0027, and D. B. Ruski M.D., 1600 North Michigan Avenue, PL 4-0988.

The subject matter for each month's seminar i

September, 1967 — Principles of Emergency Dia nosis and Treatment.

October, 1967 — Crisis Intervention.

November, 1967 — Dynamics of Family Cris Therapy.

December, 1967 — Other Common Psychiatri Emergencies.

January, 1968 — Dynamics of Suicide and Hom cide.

February, 1968 — Anticipatory Psychiatric Gui ance.

March, 1968 — Use of Paramedical Agencies i the Community.

April, 1968 — Dynamics of Industrial and Occ pational Psychiatry.

May, 1968 — Physicians as Community Ment Health Coordinators.

The entire program is sponsored by the Natio al Institute of Mental Health, the Department (Postgraduate Training of the Michigan Societ of Psychiatry and Neurology, The Michigan Ac demy of General Practitioners, and the Michiga Association of Osteopathic Physicians and Su geons. Postgraduate credit in Category I is give for the course.

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book reviews

ETHICS IN MEDICAL PROGRESS WITH SPECIAL REFERENCE TO TRANSPLANTATION. Edited by G. E. W. Wolstenholme and Maeve O'Connor. 257 pp. Little, Brown and Company, 1966.

The practice of medicine today requires that physicians decide more and more frequently the propriety of maintaining life by extraordinary means. This book summarizes discussions at a three-day symposium on ethics in medical progress organized by the CIBA Foundation and emphasizes problems peculiar to organ transplantation. Twenty-seven authorities from England, Europe, and the United States have contributed their views. Representatives of medicine, law and the ministry are included.

Such topics as the moral and legal issues involved in obtaining organs from relatives, unrelated volunteers, prisoners, minor children and cadavers are reviewed. One chapter deals with the ethical and economic problems associated with chronic hemodialysis. Emphasized are the definition of death and the decision to stop maintaining life by extraordinary means. Separate chapters are devoted to historical and ethical considerations involved in the development of blood transfusion and corneal transplantation. An outline of proposed legislation and a summary of some existing legal acts pertinent to transplantation are included. The Nuremberg Code, the Declaration of Helsinki, the Declaration of Geneva, and replies of Pope Pius XII to questions concerning "Reanimation" are reproduced in the appendix.

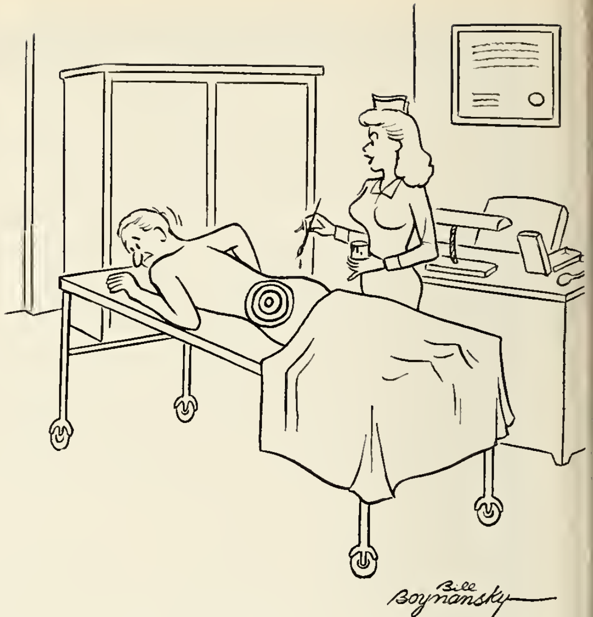
Because of the broad range of topics discussed, this book should interest all physicians active in clinical or experimental medicine. Despite its multiple contributors and many panel discussions, the editors have produced a well-written, coherent, and stimulating text which can easily be read in one or two evenings.

Jeremiah G. Turcotte, M.D.
Assistant Professor of Surgery
University of Michigan Medical Center

Parke-Davis Division Receives New Name

Parke, Davis & Company, Detroit, has changed the name of its Surgical Dressings Division to Medical-Surgical Products Division.

Parke-Davis President Harold W. H. Burrows said the name change reflects the wider scope of the division's product lines. The Medical-Surgical Products Division has four product lines: consumer first aid, hospital and professional, athletic, and related products for industrial use.



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Recalls Early Years Of Harper Hospital

The following historical note about Harper Hospital quoted from **Michigan: A History of the Wolverine State** Willis F. Dunbar, Kalamazoo, noted Michigan historian, an published by William B. Eerdmans Publishing Compan Grand Rapids.

"Harper Hospital in Detroit dates its origin t the Civil War. In 1863 citizens of Michigan sough support from the government to locate a hospita for sick and wounded soldiers in the state. On purpose of this was to reduce the travel of parent and friends who were anxious to visit hospitalize soldiers. Walter Harper, a native of Ireland an a wealthy citizen of Detroit, donated a thousan acres of land and other property to establish hospital. The trustees of this property offered th use of the land to the government, and a militar hospital was completed on the site October 1 1864. After the war it was turned over to th Harper Hospital Board of Trustees, and on Jan uary 1, 1866 it accepted its first civilian patient

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*The writer was Frank Woodford, Detroit new paperman and historian.

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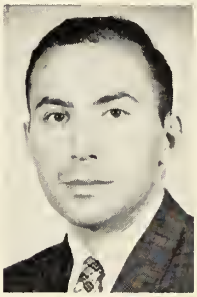
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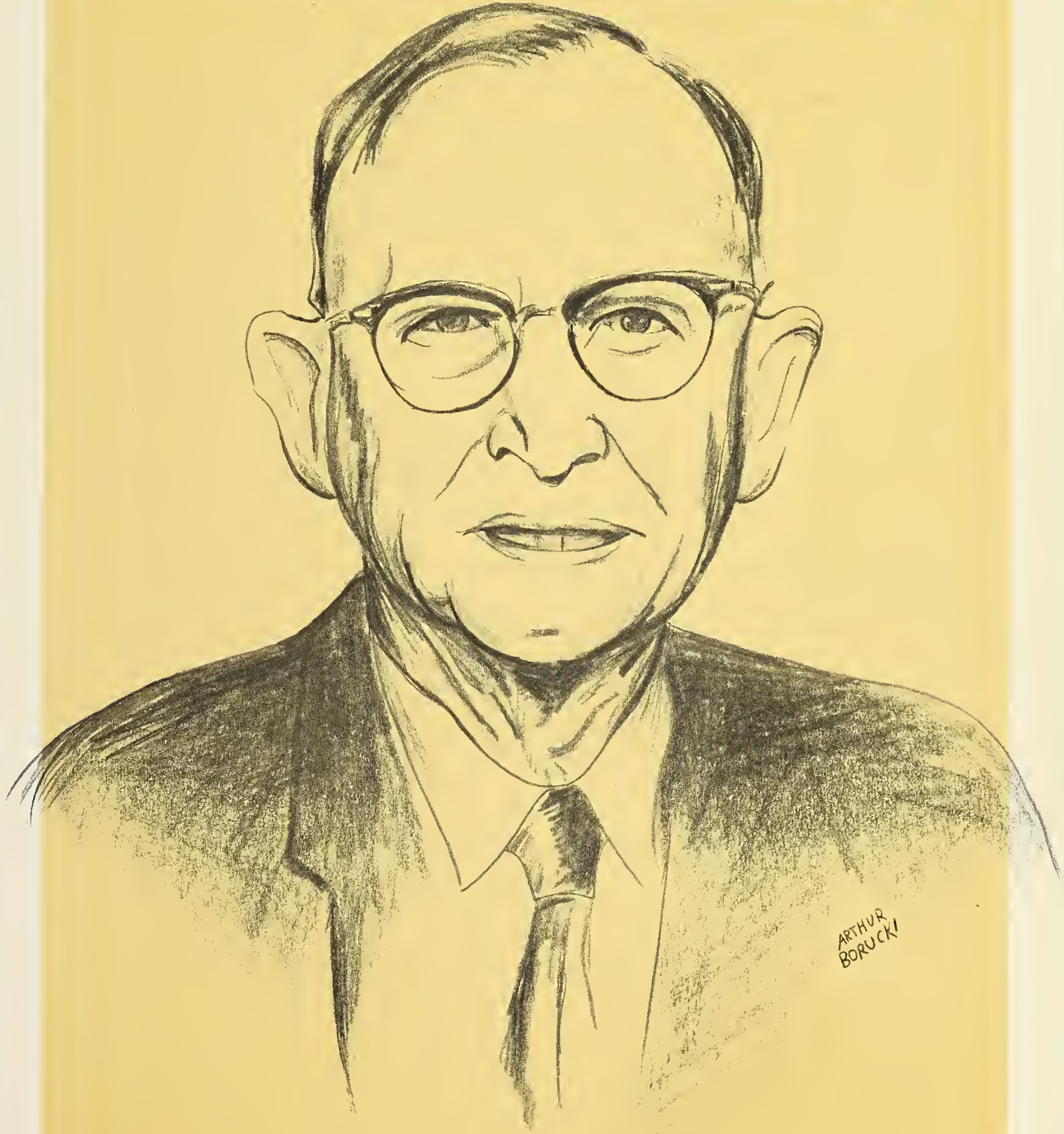

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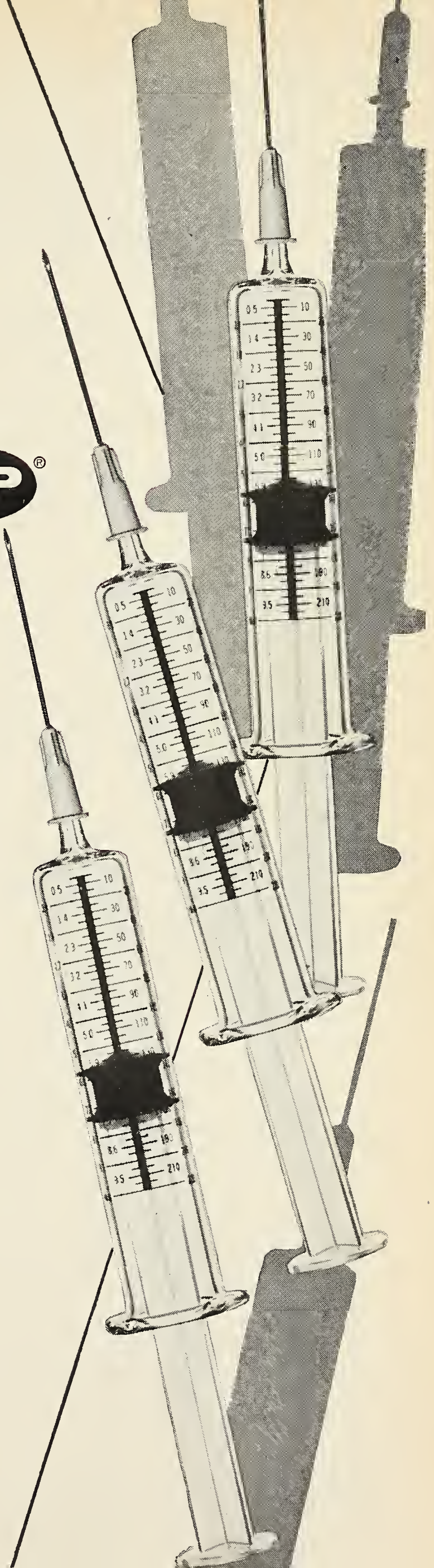

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Volume 66, Number 19

The cover likeness of MSMS Outstanding Physician of the Year, Henry Cook, M.D., Flint, was drawn by Arthur J. Borucki, of Grand Rapids. Mr. Borucki is a medical artist and photographer.

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There are 84,200* undetected diabetics in Michigan

Most of these are probably among patients over 40; the overweight; relatives of diabetics, and mothers of large babies. By the time polyphagia, polyuria, polydipsia, pruritus or other overt symptoms of diabetes appear, damage may have been done that could have been minimized. DEXTROSTIX® gives you a reliable blood-glucose estimate in 60 seconds.

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president's message

Are you committed?

As your president for the coming year, I feel a deep sense of responsibility to express your views as the occasions may arise. Let me ask:

> *Are you committed to the principle that medicine and health care can best be provided by a private, service-oriented profession, and with this philosophy: Do you believe we should endeavor to protect the confidential traditional patient-physician relationship?*

I am convinced that we are generally agreed that this philosophy is inherent in our society and we must develop plans to project constructive approaches to the provision of quality medical care within this framework to every resident of Michigan.

AMA President Milford O. Rouse, M.D., said this in his inaugural address and was widely misinterpreted and maligned by the liberal press. The fascination with broad concepts of planning in the socialistic approach to medical care parallels similar programs in agriculture, housing, education and other fields. After more than thirty years and fifty billion dollars the Hon. Orville Freeman, Secretary of Agriculture, admits the parity in farm commodity prices has not been altered. He even intimates that return to the law of supply and demand may well prove to be the ultimate solution.

The President of the American Farm Bureau Association, Charles Schuman, contends that socialism is the equal distribution of poverty. He has said, "It is the God-given right of individuals to make their own decisions." We witness this same trend in the Russian philosophy after fifty years of the Socialistic Experiment.

Should Dr. Rouse be so severely castigated for maintaining that medical care is the privilege and responsibility of the individual.

> *We, as a profession, are being assailed by the architects of Medicare and Medicaid for the imperfections of their legislation. That we constructively demurred in their wisdom is overlooked. Our early apprehensions of cost and inefficiency are becoming alarmingly apparent.*

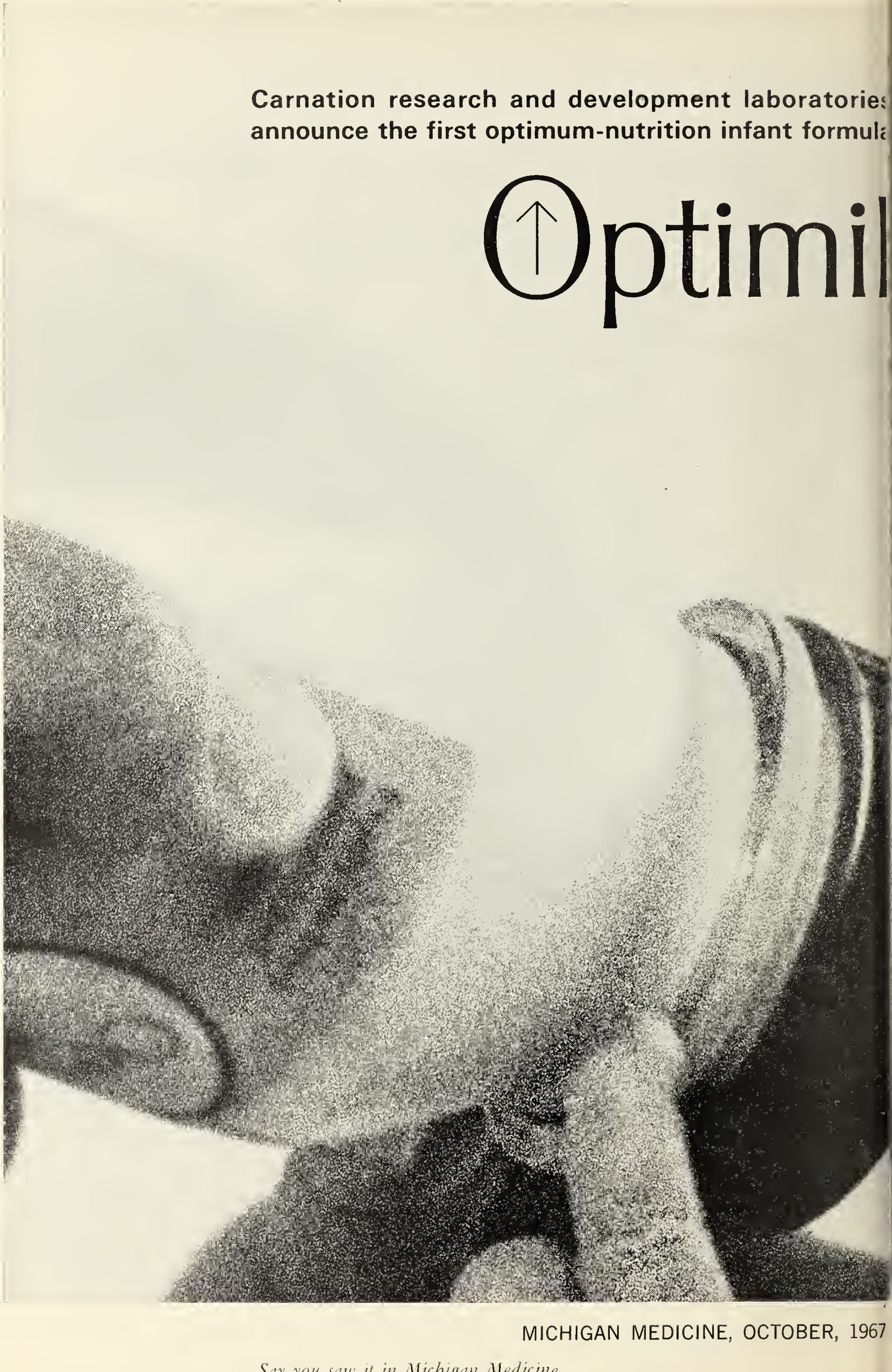
Is not also the moral degradation of the recipient?

We face as individuals and members of county, state and national societies, the imposing responsibility to research these problems and develop workable progressive alternatives. To accomplish this, we must each enhance our own knowledge so that we can discuss the issues and solutions meaningfully with our patients and friends.

> *We need constructive, consistent resistance to the socialistic vagaries and weaknesses based on political decisions. This must be accompanied by well conceived and documented program projections that provide adequate medical care for every individual by the physician of his choice.*

If we conquer, and conquer we must, then it is incumbent upon each of us to become involved. Individually. Non-involvement means resignation of individual responsibility for quality medical care for your patients.

B. M. HARRIS, M.D.



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w Optimil's marked superiority in hieving satiety–reflected by infants' requent crying—is most reassuring mothers.

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w Optimil provides protein, fat and rbohydrate in kinds and amounts ore consistent with the infant's eds. Spitting-up is minimized and n integrity maximized.

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w Optimil's superior nutritional ance of major nutrients and their nponents provides highest caloric iciency. Optimum protein and minl content assures lowest renal ute load.

Optimil is recommended as regular feeding for optimum growth and development of normal newborns; as an ideal supplement to or replacement for breast milk; as sound nutrition for prematures; and as prophylaxis against both essential fatty acid and nutritional iron deficiency.

Optimil, diluted 1 to 1 with water, provides a standard feeding formula—20 calories per oz. Supplied in new, convenient 16-oz. cans, Optimil is available for your specification at leading drug stores.

The complete Optimil system available to hospitals includes: 5% Glucose Water in presterilized 4-oz. disposable bottles • Optimil 13 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil 20 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil Concentrated Infant Formula in 16-oz. cans • Sterilized disposable nipples • Optimil Gift Pack: six 4-oz. disposable bottles of Optimil 20 calories/oz. Prepared Formula* and one 16-oz. can of Optimil Concentrated Infant Formula.

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1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquim held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.: ibid. 3. Nichols, M.: ibid. 4. McCann, M.L.; Teree, T., and Wallace, W.; ibid.

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new members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Juan E. Alojos, M.D., 31225 E. Jefferson, St. Clair Shores, 48082
Leonardo Baylon, M.D., 231 N. Main Street, Adrian, 49221
Michael Bergeon, M.D., 2115 Bay Street, Saginaw, 48602
James H. Cooper, M.D., 308 N. Broad Street, Adrian, 49221
Mehmet Ekinci, M.D., 2279 Grand Blanc Road, Grand Blanc, 48439
Leon Friedman, M.D., 2765 Flushing Road, Flint, 48504
Michael Grant, M.D., 101 Marcy, St. Charles, 48655
Arthur S. Haight, M.D., 645 Riverview Drive, Benton Harbor, 49022
Thomas C. Hall, M.D., 1100 Sixth Street, Traverse City, 49684
Thomas Hamilton, M.D., 113 W. Front Street, Adrian, 49221
Lester C. Jones, M.D., 2909 East Grand River No. 203, Lansing, 48912
Yahya Kiyak, M.D., 2216 E. Sugnet, Midland, 48640
Tock S. Lian, M.D., 216 West Tenth Street, Traverse City, 49684
John Libres, M.D., 753 N. Monroe Street, Monroe, 48161
Mary A. Ravin, M.D., 31237 Sleepy Hollow Lane, Birmingham, 48010
Edward L. Ringer, M.D., 535 S. Capitol Avenue, Lansing, 48933
Galileo A. Sarmiento, M.D., 1600 N. Michigan Avenue, Saginaw, 48602
Aaron Schneider, M.D., 26505 John R. Street, Madison Heights, 48071
J. E. Henri Simard, M.D., Pennsylvania Plaza, Petoskey, 49770
Roy Smith, M.D., 121 Beech Street, East Lansing, 48823
Joseph E. Talbot, M.D., 1311 N. Michigan Avenue, Saginaw, 48602
Paul C. Turner, M.D., 2909 East Grand River No. 203, Lansing, 48912

MDPAC Inspires Doctors to Work to Improve Government

"To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs."

* * *

That is the first purpose listed in the Constitution and Bylaws of the Michigan Doctors Political Action Committee (MDPAC).

There are many key words in that challenging objective. Michigan physicians, through their own voluntary, non-profit, independent, autonomous organization are dedicated to improve government through more effective participation.

The organization is designed not only "to promote" better government but also "to strive" to actually improve government. MDPAC has the responsibility of "encouraging" doctors to have greater political awareness. MDPAC also accepts the challenge of "stimulating" physicians and their wives to participate in candidate-support committees on the local level.

MDPAC through its meetings and materials wants more action on the part of doctors in government, but specifically works to make their participation "more effective."

It is understandable that this aspect of effectiveness be recognized because the physician's time is so valuable.

To carry out the first purpose and the other three, MDPAC has adopted a dual role to further the political knowledge of its members and to provide them a vital vehicle for concerted political action.

MDPAC invites every Michigan physician to be an active, working member. New memberships and renewals, and offers to assume important assignments may be addressed to MDPAC, Box 169, East Lansing.

Richard L. White, M.D., 820 Edgewood Place, Ann Arbor, 48103
Calvin J. Dykman, M.D., 515 Lakeside Drive, S.E., Grand Rapids, 49506
William D. Simpson, M.D., 1413 Sawyerwood Avenue, Orlando, Florida 32806
Otto F. W. Boneta, M.D., Detroit General Hospital, Detroit 48226
F. James Herbertson, M.D., 2381 Pinecrest, Ann Arbor, 48104
James D. Stroud, M.D., Detroit General Hospital, Detroit, 48226
Seymour B. Gordon, M.D., Grace Hospital, Detroit, 48201

A Building Block approach to treating hypertension

ABBOTT

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .

Pargyline Hydrochloride
Deserpidine
Methyclothiazide
220
200
180
160
140
120
100
80

Consider starting your hypertensives on this basic thiazide

ABBOTT

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE

ENDURON
ENDURON
METHYCLO-THIAZIDE
2.5 mg.
Methyclothiazide

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	 2.5 mg. tablet	 5 mg. tablet	 7.5 mg.	 10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

ABBOTT

he deserpidine component adds nhanced antihypertensive activity

he rauwolfia component of Enduronyl is de-erpidine (Harmonyl®), a purified crystalline lkaloid supplied only by Abbott. It augments nduron with its own antihypertensive and ranquilizing action.

hus the combined clinical effect of these two herapeutic building blocks in Enduronyl is reater than can ordinarily be achieved with ither alone.

o add flexibility, Enduronyl comes in two trengths: regular and Forte. Both provide 5 ng. of Enduron. The variation is where most elpful: in the deserpidine. The tablets are cored, and give a surprisingly wide and conomical choice of once-a-day doses (see elow).

hoose Enduronyl for your patients in the road range of mild to moderate hypertension. atient acceptance is excellent!

nce a day, every day

ENDURONYL FORTE
Deserpidine
Methyclothiazide

NDURONYL®

ETHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

NDURONYL FORTE

ETHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
AILY OSAGE ANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
AILY OSAGE ANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

ee Brief Summary on final page of advertisement.

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Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

EUTONYL®
PARGYLINE HYDRO-CHLORIDE
EUTONYL®
25 PARGYLINE HYDRO-CHLORIDE
EUTONYL®
50 PARGYLINE HYDRO CHLORIDE
Pargyline Hydrochloride

Once a day, every day

EUTONYL®

PARGYLINE HYDROCHLORIDE

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

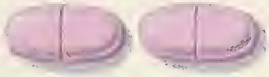
Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.

EUTRON
Methyclothiazide
Pargyline Hydrochloride

Once a day, every day

EUTRON™

**PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.**

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE	 12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	 25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	 37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	 50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON | ENDURONYL

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R

ABBOTT

nterns, Residents Urged to Join as Associate Members

County society officers and all MSMS members are encouraged to contact interns and residents and urge them to join the state society hrough county societies.

The MSMS associate memberhip is particularly attractive to nterns and residents since asso-ciate members need pay no dues and they are eligible for the various insurance programs offered by MSMS.

Often interns and residents beong to insurance programs hrough the hospitals with which hey are affiliated. But when their nternship or residency ends (most requently in the summer when many county societies do not meet and therefore applications for membership might be delayed), hey must transfer their insurance o a direct basis. Thus, when they become members of another hospital or of a medical society, they must again transfer their insurnce to group basis. Much of this ransferring could be avoided by becoming a MSMS associate member following graduation.

As associate members, these physicians would be members at least until the end of a calendar year when they could become full-time MSMS members.

Such a service could help encourage more physicians to remain n Michigan.

WANTED: BREAKING NEWS

The *Michigan Medicine* "News Extra" is mailed to all members around the 15th day of each month. Deadline for the October issue is Oct. 5. Send news and photographs to: Herbert A. Auer, Managing Editor, *Michigan Medicine,* Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.

More about doctors

Edward H. Rodda, M.D., Bay City, MSMS Councilor, has been reappointed for another full four-year term as Advisory Council member to the Michigan Department of Mental Health.

The American Academy of Pediatrics has selected Cameron Haight, M.D., Professor of Surgery, University of Michigan Medical School, and Surgeon-in-Charge, Section of Thoracic Surgery, University of Michigan, to receive the AAP's 1967 William E. Ladd Medal.

The award is given by the Academy's Section on Surgery to honor outstanding accomplishments in pediatric surgery.

Dr. Haight will receive the award during the AAP's annual meeting in Washington, D.C., Oct. 21-26, for his outstanding contributions in solving the problems associated with esophageal atresia and tracheo-esophageal fistula.

Seven members were added August 17 to the Citizens Committee on Education for Health Care by the State Board of Education. They included Kenneth E. Rowe, M.D., Laurium, Director of Western Upper Peninsula District Health Department.

Bettye Schurter McFarland, M.D., is reportedly the first woman to become medical superintendent of a Michigan state hospital. Doctor McFarland succeeds Willard Dickerson, M.D., recently retired, as superintendent at Caro State Hospital. She previously served as superintendent of Clover Bottom Hospital and School in Donelson, Tennessee.

James L. Wilson, M.D., Ann Arbor, is the recipient of the Abraham Jacobi Award presented by the American Board of Pediatrics. Doctor Wilson was chairman of the Department of Pediatrics and Communicable Diseases at the University of Michigan Medical School until his retirement this past July.

Arthur Arnold, M.D., Clinical Director of Southern Minnesota Mental Health Center for the past five years, is now the associate director of the Community Services Division of the Michigan Department of Mental Health.

The new president-elect of the Michigan Chapter of the American Psychiatric Association and the Michigan Society of Psychiatry and Neurology is Thomas A. Petty, M.D., Grosse Pointe. Doctor Petty was elected at the recent meeting of the American Psychiatric Association in Detroit.

CHANNEL 56 LISTS MARGOLIS FILM

"Parent to Child About Sex," a 30-minute color film designed to help parents communicate sound sexual attitudes to their children, will be shown by Channel 56, Detroit, on Wednesday, October 4 at 3:00 p.m. and at 10:30 p.m.

Produced by Frederick J. Margolis, M.D., a Kalamazoo pediatrician, the film has been endorsed by hundreds of civic, church, and educational organizations around the country since it was first made available 10 months ago. Growing from a nucleus of 15 prints, there are now 200 copies of the film.

The film features Stuart Finch, M.D., Chief of Children's Psychiatric Hospital at the University of Michigan, and Tommy Evans, M.D., Chairman of the Department of Obstetrics-Gynecology at Wayne State University.

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tear, moisten, compare—that's all!
M 73
100 TESTS (APPROX.)
TES-TAPE®
Urine Sugar Analysis Paper
Protect from direct light, excessive moisture and heat
Lilly
FOR URINE SUGAR ANALYSIS ONLY
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Translocation And Familial Mongolism

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IORTHVILLE

ABSTRACT — Of patients with mongolism, 3.5 ercent have 46 chromosomes in metaphase cells; xamination of these chromosomes reveals an atichment involving the long arms of two chromoomes. Such an attachment is called a translocation. Jormal-appearing parents may carry a translocaion and are therefore more likely than others to roduce mongoloid children. A laboratory test iakes it possible to detect these parents, who may lso produce normal children.

This is the second in a series of articles on posible causes of Down's syndrome (mongolism). 'he first article stressed non-disjunction and menioned the importance of advanced maternal age, iaternal exposure to X-ray and to viral diseases.[1]

In this report the phenomenon of translocation vill be described and its role in familial mongolsm discussed; two clinical cases will be described o illustrate.

About 96 percent of patients with Down's synrome have 47 chromosomes in somatic metaphase ells; the abnormal phenomenon which caused this utosomal trisomy is considered to be meiotic nonisjunction during gametogenesis in one of the arents. A small percentage of patients with Jown's syndrome have 46 chromosomes in somatic ietaphase cells. It is not possible to arrange the hromosomes from these patients into a normal aryotype even though this is the diploid number of most normal human somatic metaphase cells. A econd abnormal phenomenon involving the hromosomes apparently occurs in this smaller roup of mongoloid patients.

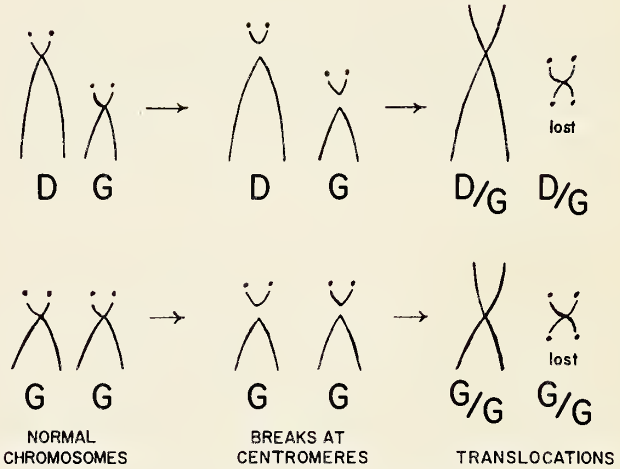

Figure 1 — Reciprocal translocation involving human acrocentric chromosomes.

RECIPROCAL TRANSLOCATION was noted nd described in drosophila chromosomes in 1929 by Muller and Painter;[2] there is a transfer of a chromosome segment to a non-homologous chromosome which occurs when portions break from two non-homologous chromosomes and exchange takes place (Figure 1). The phenomenon was noted and described as occuring in human chromosomes in 1959 by Polani[3] and subsequently by many other cytogeneticists.

Figure 2A represents a simplified karyotype of a normal individual with normal chromosomes, limited in the diagram to a pair of medium-sized metacentrics, a pair of medium-sized acrocentrics, and a pair of short acrocentrics. Figure 2B represents a normal individual with a translocation involving a medium acrocentric and a short acrocentric (D/G translocation); this individual would have 45 chromosomes with an abnormal chromosome appearing as an extra medium metacentric or "C" chromosome; his karyotype would lack one medium acrocentric or "D" chromosome and also lack one short acrocentric or "G" chromosome.

Doctor Stimson is associated in the Research Jepartment, Plymouth State Home and Training chool, Northville.

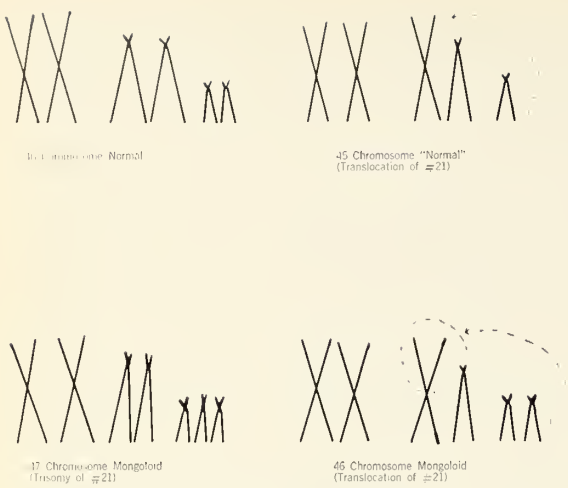
46 Chromosome Normal
45 Chromosome "Normal" (Translocation of #21)
47 Chromosome Mongoloid (Trisomy of #21)
46 Chromosome Mongoloid (Translocation of #21)

Figure 2 — Simplified karotypes of four individuals. A. (Top left) Normal person with normal chromosomes. B. (Top right) Normal person with D/G translocation. C. (Bottom left) Patient with Down's syndrome with 21 trisomy. D. (Bottom right) Patient with Down's syndrome with D/G translocation.

Figure 2C represents a typical patient with Down's syndrome with an extra short acrocentric or "G" chromosome. Figure 2D represents a patient with Down's syndrome whose metaphase cells carry 46 chromosomes but with a transfer of the extra short acrocentric to a medium acrocentric (D/G translocation). Thus, this patient's karyotype would have an abnormal chromosome which appears as an extra medium metacentric ("C" chromosome), would lack one medium acrocentric ("D" chromosome) and would have the correct number of short acrocentrics ("G" chromosomes).

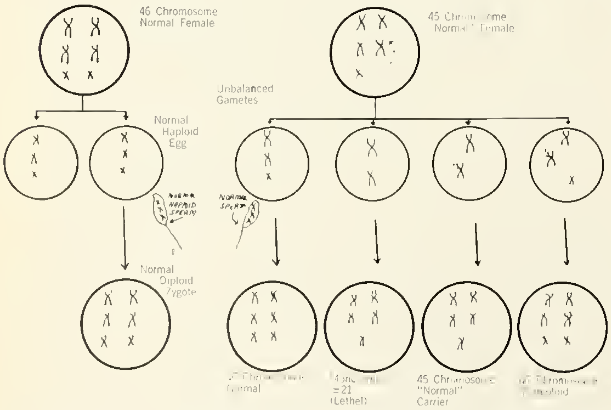
46 Chromosome Normal Female
45 Chromosome "Normal" Female
Unbalanced Gametes
Normal Haploid Egg
Normal Haploid Sperm
Normal Sperm
Normal Diploid Zygote
46 Chromosome Normal
Monosomic #21 (Lethel)
45 Chromosome "Normal" Carrier
46 Chromosome Mongoloid

Figure 3 — Oogenesis of two individuals. A. (Left) Normal individual with normal chromosomes. B. (Right) Normal individual with D/G translocation.

Figure 3 is a simplified diagram of gametogenesis in two women. Figure 3A presents normal oogenesis in which homologous chromosomes segregate to opposite poles to give rise to normal haploid ova. Figure 3B shows oogenesis as it might occur in a woman whose cells (including oogonia) have 45 chromosomes with a D/G translocation. There are three chromosomes in the oogonia without homologues which can segregate at random to the poles. This woman, who herself is physically and mentally normal, can produce four different types of ova, three of which are abnormal. If her husband produces only normal haploid sperm, her pregnancies can have four different possible outcomes: (1) a normal child with normal chromosomes; (2) a spontaneous abortion in which the abortus lacks either a "G" chromosome or a "D" chromosome. (3) a normal child with a D/G translocation (similar to the parent); and (4) a mongoloid child with a D/G translocation. Thus, this woman would be expected to have a high incidence of spontaneous abortions and one-quarter of her children would have Down's syndrome.

Figure 4 (B-E) shows some pedigrees which have been reported in recent literature in which parents with a D/G translocation have produced mongoloid children.[4, 5, 6] Figure 4A is a pedigree in which the father had a G/G translocation; of his wife's eight pregnancies, five resulted in spontaneous abortions and the other three in children with Down's syndrome; the father's two siblings both have Down's syndrome.[7]

IN A RECENT REVIEW Smith[8] reported that the frequency of translocation (1) is 3.5 percent among all persons with Down's syndrome; (2) is

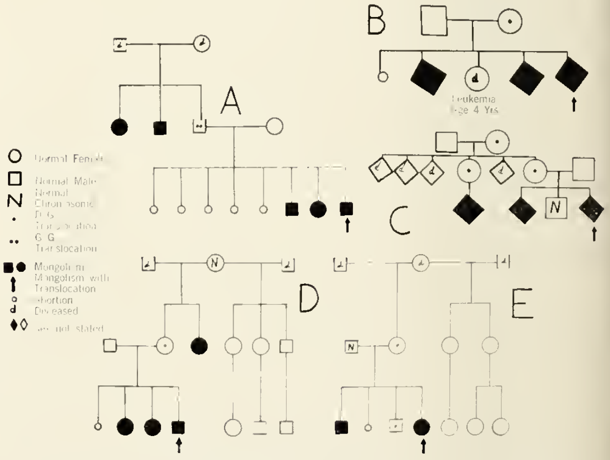
A
B
C
D
E
Leukemia Age 4 Yrs
Normal Female
Normal Male
Normal Chromosome
D/G Translocation
G/G Translocation
Mongolism
Mongolism with Translocation
Abortion
Deceased
Sex not stated

Figure 4 — Pedigrees of families carrying translocations; each family produced several patients with Down's syndrome. (Taken from literature.)

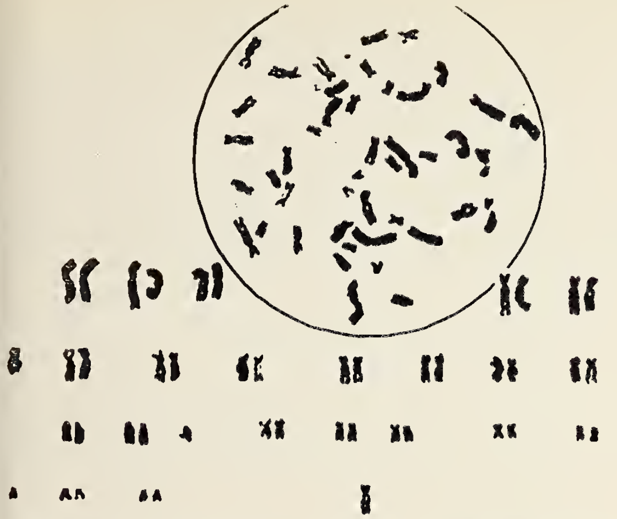

Figure 5 — Karyotype. Case I: Patient with Down's syndrome whose somatic metaphase cells have 46 chromosomes with D/G translocation.

6 percent among infants with Down's syndrome born of mothers under 30 years of age; (3) is 30 percent among infants with Down's syndrome who have one or more affected siblings. Zellweger[9] considers the following to be indications for chromosomal analysis in mongolism: (1) cases in which the diagnosis is doubtful, (2) cases in which the mother is less than 30 years of age, and (3) cases in which the mongoloid child has mongoloid relatives. One should also consider families with a high incidence of abortions or birth defects.

Following are descriptions of the cytogenetic findings as they are noted in somatic metaphase cells from two patients with clinical features of Down's syndrome.

Case I: A male was born when his mother was 23 and father 24 years of age. A maternal uncle, described as a blue baby, died in infancy; a paternal aunt, one of twins, died in infancy, cause unknown; and a paternal cousin with spina bifida also died in infancy. At age 4 days, the patient was noted to have the physical features of Down's syndrome; at age 4 months, he was found to have a congenital heart defect which was later diagnosed as an atrioventricular ostium with pulmonary hypertension; at age 19 months he was admitted to a state institution for the retarded where he has resided ever since. Now at chronological age of 13 years, he has a mental age 4 years with an IQ of 30. His low functioning at this time may be due in part to institutionalization and in part to his rather poor physical condition associated

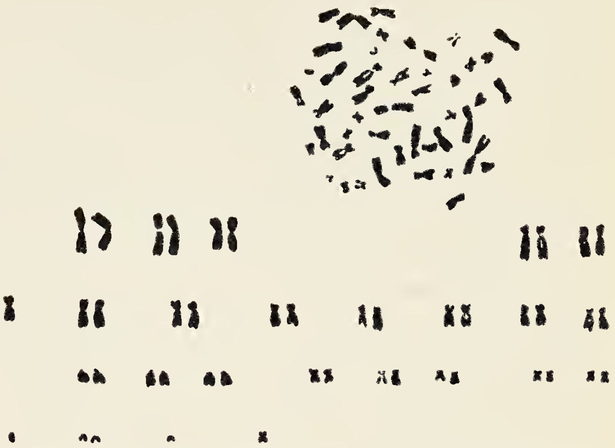

Figure 6 — Karyotype. Case II: Patient with Down's syndrome whose somatic metaphase cells have 46 chromosomes with G/G translocation.

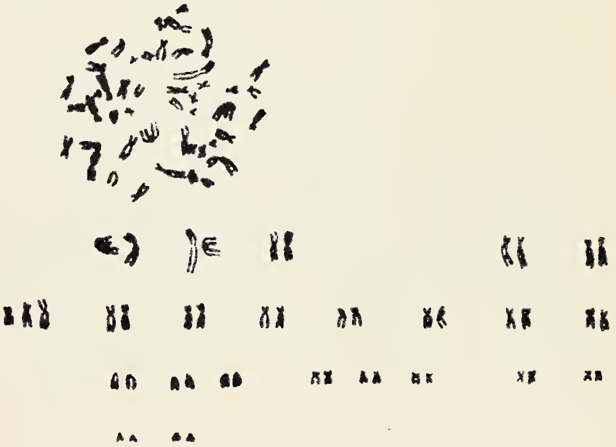

Figure 7 — Karyotype. Mother of Case II. Normal individual whose somatic metaphase cells have 47 chromosomes, XXX.

with congenital heart defect. While surveying patients with congenital heart defects, we found that this patient's somatic metaphase cells have 46 chromosomes with evidence of a D/G translocation (Figure 5). Other members of his family are unwilling to submit to venapuncture.

Case II: A male was born when his mother was 24 and father 31 years old. The mother had taken thyroid for six years prior to her pregnancy with the patient and also during the first trimester of the pregnancy. There are two normal siblings; the mother did not take thyroid during pregnancies with the siblings. Following his birth, the patient was noted to have physical features of mongolism, but at age 2 months he was thought to have cretinism. At this age his PBI was reported to be 0 mcg and somatic metaphase cells were noted to have 46 chromosomes. He received thyroid, 1/8 gram daily, for the next 3½ years. Following this, he again had clinical features of Down's syndrome rather than cretinism. Repeated cytogenetic studies indicate that somatic metaphase cells have 46 chromosomes with evidence of a G/G translocation (Figure 6). He has not received thyroid for almost a year, and repeated PBI determinations are within normal limits. His IQ is 12, which is unusually low for a patient with Down's syndrome. Somatic metaphase cells from his father and from normal siblings have 46 chromosomes and normal karyotypes. Cells from his mother have 47 chromosomes with an extra medium metacentric or "C" chromosome (Figure 7). Buccal smears from his mother have interphase nuclei with two sex chromatin masses, indicating that she has three X sex chromosomes.[10] Autoradiographic studies substantiate this.

* * *

The author is grateful to Margery Shaw, M.D., Department of Human Genetics, University of Michigan, who did the autoradiographic studies; to Mr. Edward Villis; Mrs. Maria Danckaert, A.S.C.P.; Mr. Ronald Wilson, B.F.A., P.P.A.; to Mr. James Alston for technical assistance; and to Miss Kathy Hoye for typing the manuscript.

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A Combined Drug For Asthmatic Symptoms

BY PETER P. BARLOW, M.D.
JOHN H. BURGER, M.D.
BOTH OF BIRMINGHAM

Allergic asthma is seldom controlled by one therapeutic approach. Anti-allergic regimens and hyposensitization treatment are frequently used together. Medication is necessary to reduce the frequency of attacks and to provide relief from the active symptoms. This study was designed to evaluate the extent to which a combination of ephedrine, theophylline, and hydroxyzine hydrochloride* contributes to the overall improvement in asthmatic patients when it is administered on a regular dosage schedule. Others[1-7] have found that the combined antihistaminic, anticholinergic, antispasmodic, and antiserotinin actions of this compound were especially effective.

Materials and Methods

Patients selected for study were conscientious and intelligent, and therefore presumed to be cooperative. All patients were told that they were in a study to evaluate a medication for control of asthmatic symptoms. There were 28 males and 47 females in the group of 75 patients. Ages ranged from 9 to 76 years, but the majority of patients were more than 25 years old. The study was initiated in May and continued through July. It was presumed that the incidence of complicating respiratory infections would be lowest during this period.

The series consisted of ambulatory out-patients with mild to severe symptoms of chronic asthma. All had active symptoms at the time of the study. Only three patients had had the disease for less than one year, and 38 had had it for more than ten years (Table I). Six patients had extrinsic asthma whose symptoms were primarily due to inhalant allergens, 11 had the intrinsic type (infectious), 49 had both intrinsic and extrinsic asthma, and 9 had aspirin-sensitivity asthma (triad of nasal polyps, asthma, and aspirin allergy) (Table II). Concomitant upper respiratory allergies were present in 63 of the 75 patients (Table III).

Prior to initiating the study 33 patients were taking steroids, and the majority were taking other medications including bronchodilators, sedatives, expectorants, tranquilizers, and antihista-

Table I
Duration of Symptoms

Time	No. of Patients
Less than 1 year	3
1 year to less than 5	16
5 years to less than 10	18
10 years or more	38
Total	75

Table II
Categories by Type of Asthma

Type	No. of Patients
Extrinsic	6
Intrinsic	11
Mixed extrinsic and intrinsic	49
Aspirin sensitive	9
Total	75

Table III
Associated Allergic Rhinitis

Nasal Allergy	No. of Patients
Perennial	25
Seasonal	19
Perennial and seasonal	19
None	12
Total	75

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*Marax®. J. B. Roerig Division, Chas. Pfizer & Co., Inc. Each tablet contains ephedrine sulfate, 25mg; theophylline 130mg; and hydroxyzine hydrochloride, 10mg.

mines. Nineteen were taking no concomitant medications, and three of these had never taken a bronchodilator. Of the 75 patients, 56 were receiving appropriate immunologic hyposensitization therapy in maximum maintenance doses; the allergic state had not been completely evaluated in most of the others.

During the study concurrent medication was used as the investigators deemed consistent with clinical practicality. Thus the patients were not treated by rigid statistical patterns, but exactly as they would be if a study were not in progress. The only variable which was likely to produce change was the test drug since it was the only new addition to our usual regimen.

Although some patients previously had taken the compound being evaluated, none had used it for at least one month before participation in this study. If feasible, all bronchodilators were discontinued for at least three days before the study began.

On the first day of the study a base line for pulmonary function was obtained, and then medication was prescribed. Pulmonary function tests consisted of measurements of total vital capacity (TVC), one-second forced expiratory volume (FEV_1), and mid-maximal expiratory flow rate (MEFR). The recording instrument was the Jones Pulmonor (waterless spirometer). The majority of patients benefitted from a Marax dosage of one to one-half tablets four times daily. Each patient was examined one week, three weeks, and six weeks later. Follow-up visits were continued at two- to three-week intervals if necessary.

Twenty-two patients were treated for one to four weeks, and 53 were treated continuously for five to 12 weeks. Chest examinations and pulmonary function tests were done at each visit, and thus the status of the patient was objectively evaluated. Also, the patients reported their own subjective impressions of their health. The final evaluation at the end of treatment was based on our clinical judgment which was influenced by the findings on the pulmonary function tests.

Results

Although the results of all three pulmonary tests were taken into consideration in the evaluation of the patient's respiratory function, the strongest emphasis was given to results of the MEFR and FEV_1. In our opinion these are better indicators of pulmonary air flow and patency of the bronchial tree than TVC results.[8]

Pulmonary function was considered improved if the MEFR and/or the FEV_1 reading increased by 20 percent or more. Function was considered worse if the readings were decreased, and no change if the figures fell between zero and 20 percent in both of the tests as compared to the base-line reading obtained at the first visit. Although many patients state they feel improved even when pulmonary function is but slightly increased, we have chosen a minimum of 20 percent change as a criterion of improvement. This choice is confirmed by others working in pulmonary physiology testing.[9]

At the conclusion of the study pulmonary function (Table IV) had improved in 61 patients and decreased in nine. It had not changed in five patients, but of these three initially had normal functions. To help the patients determine their status of health as related to their asthma, they were told to adopt the following ratings: excellent, if they felt they were virtually free of asthmatic symptoms; good, fair, or poor if they were 75, 50, or less than 50 percent free of symptoms, respectively. At the beginning of the study the patients rated themselves as follows: two patients considered the previous control of their symptoms excellent, 15 considered the control good, 38 considered it fair, and 20 considered it poor. At the conclusion of the study the patients were asked to evaluate the status of their health, again using the same criteria. Ten considered the present control of symptoms excellent, 51 considered it good, nine thought it fair, and five considered it poor.

Our final evaluation of the patient's health was partly subjective. It was based not only on pulmonary function results, but also on our own in-

Table IV
Pulmonary Function After Treatment

State of Pulmonary Function	No. of Patients
Improved	61
Decreased	9
No Change*	5
Total	75

*Function initially normal in three of these and, therefore, only two patients showed no improvement in pulmonary function.

Table V
Results as Evaluated by Patients and Therapists

	Patient's Evaluation		Authors Evaluation
Result	Previous Treatment	Study Treatment	Study Treatment
Excellent	2	10	12
Good	15	51	57
Fair	38	9	3
Poor	20	5	3
Totals	75	75	75

erpretation of the patient's symptoms and on the patient's evaluation of himself. Accordingly, a rating of excellent was given to 12 patients, good to 57, fair to three, and poor to three. In general there was close agreement in the ratings given by the patients and by the authors. This also correlates with the pulmonary function results (Tables IV and V).

Side effects were reported in 16 of 75 patients. None was experienced by 59 patients. Nervousness was reported by 12 patients, gastrointestinal upsets by three, and urinary retention by one. There were two additional general complaints that could not be related directly to the medication. The frequency of nervousness was considered relatively low considering the fact that the patients were taking an ephedrine-containing medication.

Discussion

The complexities of asthma preclude reliance on any one parameter for an indication of improvement. An increase in the frequency of attacks can offset near-normal findings on a chest examination; an increase in the severity of attacks can offset a decrease in frequency. Therefore, in this study the determination of a change in a patient's status was based on our clinical judgment. This, in turn, was based on the results of pulmonary function tests, chest examinations, and interviews with the patient.

During the interviews we attempted to determine if a patient's report of a change in his clinical state was prompted by an actual change in the status of his asthma or by some factor indirectly related to his asthma. Indeed, a patient sometimes reported that his asthma had improved or grown worse when it really was family relations, business conditions, or some other factor that had improved or grown worse. Therefore, the rating that we gave the patient was not necessarily the same as the one he gave himself.

It was apparent that this medication taken on a regular dosage schedule not only maintains the asthmatic comfortably, but also reduces the frequency of attacks. Thus, the administration of a bronchodilator drug regularly every four hours provides a continuous therapeutic effect which helps prevent the clinically apparent peaks of bronchospasm. In ten cases a dosage response was demonstrated on pulmonary function tests.

Also, the dosage of steroid was reduced for 17 of the 33 patients who were taking steroids when they entered the study. Of the 17, 16 had a 50 percent or more reduction in this dosage. The authors felt that cases involving the elimination or reduction of steroid therapy would be of particular interest. We have, therefore, included the following:

Case 1: One of the aspirin-sensitive patients who has suffered increasingly severe symptoms in the past 20 years, was able to stop her prednisone 10mg daily and continue on Marax qid.

Case 2: A 9-year-old girl with progressive asthma symptoms over the previous three years had needed steroids for 1½ years. Her daily maintenance dose of 10mg prednisolone was reduced successfully to 2.5 mg daily while taking ½ a Marax tablet qid.

Case 3: A 22-year-old girl had an overlay of nervousness and tension to a four-year history of increasing asthmatic symptoms requiring 10-20 mg prednisone a day. Marax qid allowed her to reduce the steroids to less than one 5mg prednisone per week.

Case 4: A 36-year-old female patient with a history of severe asthma since age 13 had the following problems: bronchial asthma, allergic rhinitis and sinusitis, nasal polypi, and ASA sensitivity. Nasal polypi had been removed three times. On ½ Marax tablet qid she was able to reduce her steroids from 2.4mg betamethasone daily to 0.6mg daily.

Case 5: A 56-year-old female with an 11-year history of recurrent asthma was tapered off steroids and had a corresponding decrease in FEV_1 from 700 to 500 and MEFR from 17 to 15. After an additional three weeks on Marax alone the FEV_1 rose to 800 and the MEFR to 23 which compares favorably with her initial tests of 900 and 25 respectively while on prednisone 5mg daily.

Case 6: Two examples of interest are patients whose steroids were discontinued at the inception of the study. Neither needed reinstitution of steroids. One of these, who considered her previous treatment as fair, considered Marax excellent therapy; the other, who considered her treatment excellent on steroids, rated her Marax therapy as good.

Marax was well-accepted by the group. At the end of the study 47 patients asked to continue it because they preferred it to previously prescribed medications.

The safety of this medication was inadvertently illustrated by the experience of one obese, ambulatory patient with very severe asthma. She was instructed to take one tablet every four to six hours, or four to six tablets a day. Having misunderstood the instructions, she took four tablets six times daily, or 24 tablets daily for four days. At the end of this period she experienced nausea, vomiting, abdominal cramps, crying spells, and nervousness. Interestingly, these symptoms were brought to our attention only when she called to ask for additional tablets. The symptoms disappeared 48 hours after medication was discontinued.

Summary

Seventy-five patients with active symptoms of mild to severe chronic allergic asthma were studied. Marax was administered on a regular dosage schedule, and other anti-allergic therapy (hyposensitization treatment, antibiotics, steroids) was given as required. Pulmonary function increased in 61 patients, remained unchanged in five patients (function was initially normal in three of these), and decreased in nine patients. The dosage of steroids was decreased in 17 of the 33 patients.

Results of treatment were evaluated by the patients and ourselves. At the end of the study period the control of asthma was considered excellent by ten patients; 51 considered it good, nine thought it fair, and five considered it poor. The authors considered that control was excellent in 12 patients, good in 57, fair in three, and poor in three.

Marax was well-accepted and well-tolerated by the group, and side effects were few and mild.

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Clinical Investigation: Why Make It More Difficult?

BY W. E. HERRELL, M.D.,
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INTERNAL MEDICINE DIGEST

Many investigators have been pondering the effect of the policy statement of the Food and Drug Administration regarding the use of investigational drugs on humans. In fact many have even decided to abandon their interest in a field in which they have spent a great part of their professional life. This is, indeed, most unfortunate.

It seems to me that the issue at the moment is the question of whether or not the public's interest is better served by rigid controls or if, in fact, the public may be the loser because of the regulations. The real issue is how many lives were lost in the past because of the lack of FDA regulations versus how many lives will be lost because the investigator is not permitted, or does not feel that he is permitted, to investigate because of these restrictions. It would, indeed, be tragic if more lives were lost because of the existence of too many regulations.

Let us examine for the moment a statement contained in the "Letters" section of *Science* (April 21, 1967) which was written by Dr. Maurice B. Visscher, an eminent scientist. This is what he had to say: "An example of the general bureaucratic preference for negative rather than positive action is the case of a colleague who was for more than three months refused permission to test for a new purpose a potentially life-saving drug which had already been used, without evidence of toxicity, on half a million humans in other countries for a different purpose. He had submitted a great deal of toxicity data but still more was demanded. It happens that a million or more persons a year die of ventricular fibrillation, which this drug might prevent in many instances.

What Dr. Visscher is saying is that many people may die of ventricular fibrillation while the investigator is waiting for the FDA to satisfy itself that a potentially *safe* drug is *safe*. If this is the case, then indeed the public interest is not being properly protected. One has to agree with Visscher that the public interest demands that the risks of inaction, as well as the risks of action, must be taken into consideration in decision-making regarding the clinical testing of drugs.

I do not propose to examine in detail the declaration of Helsinki, for the simple reason that many editorials and speakers have examined it to the point of exhaustion. I am sure that most people in clinical investigation could by now recite it from memory. The real fact of the matter is that we now have the laws written by Congress, and the FDA is charged with the responsibility of the administration of these laws. If experience should show that the law as it was written is not in the best interest of the public, as well as the scientific investigator, then it is high time that the Congress be asked to correct any injustices that may exist and rewrite the law as it has in a thousand other instances in the history of our government in this country.

It is my conviction that it is not in the best interest of the patient under many circumstances to inform him that he is to receive a new drug or, even worse, to inform him that he is to receive a placebo. Further, as I have said elsewhere, there are times when it is unethical and immoral to even consider the use of a placebo when one investigates a new therapeutic agent in the treatment of a life-endangering disease.

The trouble in which we find ourselves today lies in the fact that the government and some individuals in high places are trying to legislate morality, and it simply cannot be done. Morality is a part of the inner man, it is like his religion, it cannot be legislated.

Every responsible investigator knows, or should know, that it is wrong to carry out human experimentation when the experimentation may be hazardous and not in the best interest of the patient. To return for a moment to the matter of the use of the placebo (control) to establish the effect of a new therapeutic agent in the treatment of a heretofore uniformly or almost uniformly fatal disease, this in my opinion is immoral. On the other hand, there is nothing immoral or unethical about using strict controls when one investigates the effect of a new agent or a new method in the treatment of a non-life-endangering disease.

It seems to met that there must be a *middle-ground* in this whole area of clinical investigation. By this I mean, surely we must be able to find an area which lies somewhere between too much and too little regulation.

I have one suggestion that may be worth consideration. Let's return the matter of the best interest of the patient or the research subject to the investigator in a manner that should be acceptable to him. Most good clinical research is done in medical institutions. By that I mean in hospitals which are either government owned, privately owned, or those attached to teaching institutions. Likewise, much good clinical investigation is carried on in clinics. Every institution, either privately or publicly supported, should have a director of research or a research committee. The investigator should first of all register his study with the committee or the director of research and these people should be charged with the responsibility to see that the best interest of the patient is protected before approving a project to be undertaken. The matter of safety of the therapeutic agent and toxicity data would be carefully appraised before the study wa undertaken. If approved by the director or th committee, the investigator would then from tim to time make progress reports to them, and finall the investigator should be allowed to proceed an to publish his data. This method does not exclud the individual in private practice from doing clinical investigation since he, also, usually has a hospital or an institutional affiliation available to him He also would simply outline his project to the research committee or the director of research in th institution with which he is affiliated.

In my opinion, the whole matter of informe consent is absurd. If the investigator wishes to inform the patient that he is going to try a new drug or a new method which in the opinion of the investigator might be helpful, all well and good; bu if, in his opinion, it is not in the best interest o the patient to tell him, let's forget it! If, as I hav already indicated, the study involves a non-life-endangering disease and a control series is justified, it is wholly ridiculous for a committee or a government agency to rule that the patient must be so informed.

There is another very important consideration in this vast area of development of new therapeutic agents, namely, the pharmaceutical industry of this country. This industry has supported clinical investigation in every possible way. The industry has also invested millions of dollars in the development of new drugs, and they have in their institutions scientists and businessmen who are individuals of great ability. If they (the industry) cannot function effectively because of ever-increasing government controls, then it is high time something be done to correct any inequities that now exist. The public, I might add, also has, in addition to its health involved in the development of better drugs, millions of dollars invested in the stock of these companies. Thus there is in addition to the health factor a great economic factor involved in clinical investigation. It is surprising that the public has not before now been aware of the possible impact of too much government control on their financial investments in the pharmaceutical industry.

Finally, it is my belief that most individuals in clinical research and industry are men of good character and with a deep sense of moral and ethical responsibility. To be sure, there are a few who would not qualify by these standards, but I repeat that the Congress will never be able to write laws to eliminate this minority. Let the institutions and the individuals in the institutions in which the clinical research is to be done, as well as those in the pharmaceutical industry, police themselves.

How to Work With a Troubled Married Couple

BY JOSE J. LLINAS, M.D.,
EAST LANSING

ABSTRACT — A disturbed marriage presents a very conflicting symptomatic picture. A review of normal marriage, personality growth, and deviant patterns in these two areas clarifies the role of the physician as a marriage counselor.

He can encourage husband and wfe to find their own answers in a mature quest for a better, more satisfying relationship to each other.

Marriage counseling is a general term encompassing a number of ways to help couples in difficulty through discussion with a trained professional.

There is a wide variety of techniques involving individual, joint, group, or family treatment and perhaps as many approaches to counseling as there are counselors.[1, 2]

Qualifications

A physician who is interested in doing successful marital counseling needs:

1. A clear understanding of the normal aspects of a marital relationship.
2. A working knowledge of normal personality growth and development (how people go from early infancy into mature adult life and how their personality changes in the process, and
3. Some idea of the nature and causes of deviant behavior as they apply to marriage and to personality growth.

Armed with this knowledge the physician will be able to understand what gets in the way of people when they are disturbed, how the roadblocks to growth and better adjustment can be eliminated, and how to encourage the development of more realistic and healthier attitudes about life.

Normal Marriage

"The normal family," Stuart Finch says, "may be described only with the stipulation that cultural variations provide considerable complexity. In such a family, however, the father is a mature, masculine individual who accepts and is comfortable in the parental role. He loves and respects his wife and establishes an adequate home in which to raise a family. The mother is a feminine person who accepts and fulfills her roles as wife and mother. She respects her husband, and he respects her.

"Each of them is dependent upon the other and yet retains a certain amount of independence. These parents provide a united parental front to their children. The youngsters realize that the parental relationship is solid and indivisible. There is no authoritarian parent, and there is no passive one. Rather, there are two adult individuals who represent a consistently firm atmosphere as well as a positive and loving approach.

"Although disagreements will occur from time to time, both the children and the parents know they do not represent a real division in the relationship between mother and father.

"Normal parents are mature and intuitive in their handling of the children. They do not need innumerable rules from books or from specialists.

"The mother welcomes the birth of a new infant and understands his dependent needs during his first year of life. She is aware of the necessity to provide discipline and training for her youngster as he becomes a toddler. The father, during the child's first year, is not only interested in the infant, but is willing to give his wife assistance in

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the care of the child. This includes bathing, changing, and feeding the infant. The father's interest becomes somewhat more active and evident as the youngster grows and begins to join the family in various activities."

"This normal family," Finch ends, "may have one child or several, and may be wealthy or in a lower income group but its important features are that the parents have a strong bond between them, that they enjoy their children, and that they are capable of providing secure, consistent parental management of these children at all age levels."[3]

Stages of Emotional Development

How do parents become mature individuals?

"It is in youth that we plan our chief habits and prejudices," Benjamin Franklin wrote many years ago, "it is in youth that we take our party as to profession, pursuits, and matrimony."

We trace the roots of emotional maturity to our early years. Emotional growth can be compared to physical growth and is, of course, related to it.

Physical development can not occur without the satisfaction of basic physical needs (food, shelter, care, and protection). Emotional development is hampered if there is no satisfaction of basic emotional needs (security, warmth and affection, acceptance, and guidance).

We come into this world as helpless infants who could not survive without care. Just as the mother's body envelops the child for nine months, so her love and affection will have to envelop him for many months to come. Independence and autonomy for the human being evolve painfully slowly.

For some people, who are not able to "cut the umbilical cord," it may not come at all.

Throughout his first year of life, the most important psychological characteristic of the baby is his absolute dependency on the environment.

One basic piece of research, which was done by Doctor Rene' Spitz[4] several years ago, showed that babies cared for in orphanages with limited nursing personnel had a very low survival rate, despite adequate nutrition and hygiene. If the human infant is not stimulated by human contact, if he is not abundantly picked up, held, cuddled, hugged, and given vast amounts of warmth and affection, he goes into a state of "marasmus," disinterest, arrested development, "depression," and, not infrequently, death.

This sense of being close to another is so important that when later on in life men develop serious mental illness, we say that they are "out of contact" or "out of touch."

It is always impressive when one hears a man or woman say, "I know my parents loved me, but they were not very demonstrative," or "my kids, I love them, but I'm not the hugging type."

The pathetic truth is that the very existence of love that does not get expressed is in doubt.

There are families where this kind of emotional starvation is passed from one generation to another; and although these people have to resolve their fear of expressing themselves, they also need re-training — they need to learn anew the complicated ways of human love and understanding. A review of developmental stages throws much needed light upon the unfolding of the capacity to love, oneself as well as others.

The Birth of Independence

After the first year of life, if we continue to follow the blossoming of the child's personality, we still see a great deal of dependency upon the mother, but we also begin to see the rudiments of more independent behavior.

By the end of the first year the child begins to walk and gain mastery of his muscular system; at the same time he is expected to exercise a degree of control over his sphincters. Not entirely by coincidence, it is at this time that he also learns the full meaning of the word "no" ("Don't touch!" "I don't wan'na!").

Unless the mother continues to be supportive and understanding and allows room for autonomy, and even some rebellion, the child will find it hard to solve the conflicts of this stage of development and continue his emotional growth.

Some people that we see later as adults, seem not ever to have surmounted some of these problems. One example of this is the marital partner who is usually described by the spouse as "too independent." They do not want any counseling because they "should be able to take care of their own problems."

In reality many of these individuals do not inwardly feel that they can stand on their own two feet, and their covert desire to rely on other people (and resentment of this) is so great that it at times scares them, if they get a glimpse of it. Their lives seem to be a constant struggle to show how very capable they are and how very little they need other people. They do not take kindnesses or favors very graciously as they are always afraid of the strings attached, and they are often afraid of doctors and other parent-like professionals.

Rudiments of Love

The next stage of emotional growth spans the est of the pre-school years. It is usually described s the period of the family romance because in the ormal family there is a very strong sentimental ie between the child and his parents. It is tinged ith love and possessiveness for the parent of the pposite sex, and love, but also rivalry and competition, with the parent of the same sex.

If these feelings are not understood and accepted (and ultimately disappointed), it is very hard for the child to give up these infantile attachments and eventually be free to love another person in a mature way. Peer relationships, brothers and sisters, are also important at this time because many aspects of jealousy and resentment are easier to understand and accept in this context.

We all know glaring examples of the failure to dissolve the strong romatic tie between child and parent. The man or woman who stays home "to take care of the folks," while not as frequent today as it was years ago, is by no means uncommon.

The husband who begrudges every bit of attention the wife gives to her own parents is many times faced with this problem.

It is helpful to remember that it is not only the child who is caught in the complicated mesh of these feelings. The parents also react with intensity in the same direction, and it is usually the parental response which holds the key to an adequate resolution of the feelings.

A not uncommon example of unresolved attachment is shown by the father who can never really approve of any dating companions for his teen-age daughter, or the possessive mother who thinks that no girl is good enough for her adorable son.

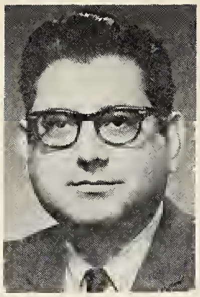
Tolerance and a sense of humor are the best antidotes against extreme attitudes of this sort. Many years ago, Ogden Nash wrote a poem entitled "A Song to Be Sung By the Father of Infant Children," in which he describes his ungenerous feelings about the baby boy who would grow up one day to marry his daughter Jill:

"I'll pepper his powder and salt his bottle
And give him readings from Aristotle.
Sand for his spinach I'll gladly bring
And Tabasco sauce for his teething ring.
Then perhaps he'll struggle through fire and water
To marry somebody else's daughter."

The Early School Years

Finally, if the child successfully masters his early conflicts, he is ready to start school and is curious and eager to learn. This is a period of slower, if steady, psychological growth.

Not until the turmoil of adolescence do we see again the struggle between strong desires and equally severe renunciations.



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The Teen Years

Adolescence seems to be the second chance a human being gets to settle his psychological scores. It is characterized, as we all know, by a strong tendency to be grown-up one day, with a similarly strong pull to be childlike the next. There is overconfidence and elation one minute, miserable insecurity and sadness the next.

Some of the old conflicts which had apparently been resolved make a renewed appearance and have to be dealt with again. A degree of maturity finally arrives, with a more confortable relationship to the opposite sex and some definite vocational goals.

Adult Years

When is an adult person ready for marriage? The obvious answer should be something like "When he is grown-up enough to satisfy his own needs, secure enough to take on added responsibilities, wise enough to tolerate imperfections in another, hopeful enough to help correct them without smugness, martyrdom, or contempt," and so on.

People who are not entirely grown-up find it very hard to help each other achieve a greater degree of emotional maturity. The tragedy of many a teen-age marriage (and of many "older" marriages which are in essence adolescenct affairs) is that husband and wife will ask from each other what they were never prepared to give. They end up some distance from normal expectations and become deviant in one way or another.

Deviant Marriages

Husband and wife appear then to the observer as full of unsatisfied, conflicting needs. "I want you to take care of me," the wife appeals to the husband. "But *I* thought *you* would take care of me!" is the disappointing, covert answer.

During the fourth conjoint interview with their therapist, a young married couple mentioned the following incident. "I was putting up the storm windows yesterday," the husband said, "and Helen dashed out of the house because there was a spot of dirt on the window, and she wanted to clean it. This made me furious, and we got into an argument — I didn't know why!"

In talking about it, he felt that the wife's concern about the dirty window was a reflection on him, but he wondered why he was so sensitive about it. Then he remembered that he had come home with a headache and wanted to lie down, but the wife had insisted that he put the window up. They then recollected many other similar episodes where they subtly demanded care and attention from each other, did not get it, and ended up having an argument.

As we face marital difficulties, therefore, one of the things we need to ascertain as soon as possible is the nature of the conflict (more commonly, several ones) between the spouses and how this relates to their own emotional growth. When we know enough about the situation, we usually find in place of the adult marital relationship some variant of a parent-child involvement.

The situation is further complicated in practice by the fact that the relationship is a complex one, and the areas where spouses function as parent or child may be intermixed. For instance, a wife may be quite competent to handle the management of the household, but frightened, helpless, and inadequate in her role as a sexual partner.

Solution of the problems will come with an increasing ability to identify areas of immaturity and to encourage further personality growth in both husband and wife.

How does one obtain information about a person's emotional growth and psychological maturity? How does one find out what gets in the way of people as they attempt to learn more about their problems? And, finally, how does one help them to eliminate the roadblocks in their path to a more sound adjustment and a happier life?

The answer, at least in part, is as old as the art of medicine itself. The basis of a good medical practice has always been the taking of a reliable, complete history. As the description of the difficulties evolves, it is hard not to put things together and delineate some of the required answers.

History-Taking In Marital Problems

When taking the usual medical history, the physician asks questions to ascertain the unfolding of the presenting problem. He is able to do this because he knows a great deal about the normal physiological state and the changes that come abou when that state is disturbed.

As he gathers information, he thinks about general diagnostic possibilities which come to mind because of his previous training and experience.

The situation is somewhat similar in the exploration of emotional problems. Once the physician has a working knowledge of personality growth, some understanding of the "physiological state" in marriage, and a genuine interest in helping people attain more satisfactory outcomes in their life conflicts, he is ready to embark on a trip of discovery with a willing married couple.

It will help a great deal if among the elements in his little black bag of psychotherapy the doctor has the wisdom to carry

1. some understanding of himself, and a degree of insight into the nature of his own marriage, and

2. much tolerance for the foibles of his fellow men, as well as a heavy dose of patience and fortitude in the face of their shortcomings.

The Initial Contact

Most people who do marital counseling seem to agree on the advantages of seeing both partners together from the start. There is no great objection to interviewing them separately, and the physician may well do so if he feels more comfortable, but in so doing the physician misses a golden opportunity. Taking a history from one spouse in the presence of the other gives them both an equal chance to learn and clarify issues and many distortions can then be straightened out.

As one asks about the families of origin, the remarkable discovery may be made that the spouse represents, at times, somebody from the other partner's past, and perhaps simultaneously and in some ways, somebody taken from his own life history.

A couple in their mid-thirties were seen because of the wife's depression and unhappiness. In a joint interview the wife described her fear of getting angry at her mother, a tyrannical and insecure person who always "had to have her own way."

Asked what she was afraid of, the wife said, "I don't know — I don't think she will strike me . . . I'm afraid of her criticism." She then looked at her husband and, much to her own surprise, added, "It's the same with you!" The comment lead to a spirited and searching discussion where fear of the mother and fear of the husband were found to be stumbling blocks in her ability to as-ert herself as a grown woman. The husband was ust as interested, as he began to see that his wife's pisodes of "depression" did make some sense, fter all. They would usually come about at times when she particularly feared real or fancied dispproval from him.

In a particularly productive interview, a maried secretary referred to her husband as "doctor" o-and-so. She went on laughingly to explain that he husband was as much of a doctor as the therapist, since with the husband's help she had finally ound out that the "sick headaches" she comlained of were usually the result of incidents where she had resented somebody (boss, co-workr), but had not felt free to express her intense nnoyance. Further exploration of these feelings s they related to the husband disclosed some of he etiological factors in a persistent sexual frigidity.

"Keeping The Marriage Together"

If a couple do not wish to remain united and work out their problems in a helpful and reasonbly cooperative manner, there isn't much that the doctor can do to keep them together. At times one or the other of the spouses (occasionally both of hem) would like the physician to take the responibility for the situation to the extent of being for or against separation.

The doctor (just as the lawyer, the judge, the minister, and other representatives of society) hould have an interest in protecting the integrity of the family. When a couple consults an expert bout their problems, furthermore, there is some hesitation about more drastic steps. To that exent, at least, they show their willingness to stick o one another.

On the other hand, one should remember that usually people who are stable, mature, and have no great unresolved emotional conflicts in their ife, naturally gravitate toward people similarly ndowed. The opposite is also true to a degree, and the expert psychiatrist who wrote a book enitled *Divorce Won't Help,* had this particular type of marriage in mind. The case of the woman who married a man only to find out that he is an alcoholic, divorces him, and ends up a short time ater married to a man similarly afflicted, is much oo common.

Taking Sides

The astute physician is aware of the paradox so frequent in human affairs that what appears clear and self-evident at first seldom turns out to be so on further, more careful exploration. Here, as in many other areas of human endeavor, appearances are deceptive.

A young woman consulted a psychiatrist about her inability to enjoy sexual relations after six months of marriage. She said that "sex did not bother her" and confided that she came at the insistence of her husband, who was quite disturbed about her "coldness." After a few months of conjoint treatment it became apparent that both husband and wife were extremely infantile in their attitude about sex. The husband finally realized that, in his choice of marital partner, he had been guided by a strong desire to show off, and his wife's failure to respond to him was of concern mostly for similarly selfish reasons. On the other hand, the wife began to see the roots of her problem in a deep animosity against men, connected with significant feelings about both her father (who did not think much of women, and was unable to show warmth towards them) and her mother, who thought little of herself as a woman. Fortunately, they were able to bring changes about which improved greatly their ability to enjoy each other in sex as well as in other areas of life.

The wife of a severe alcoholic seen in consultation only once, after describing her husband's excessive drinking, their constant bickering, and gross lack of elemental human consideration for each other, finally said that she knew all of her problems were due to the fact that they both came from different parts of the Old Country and that she had married beneath herself.

When it was gently pointed out to her that in some ways her behavior was as child-like and inconsiderate as that of her husband, she abruptly left in a huff, saying that she "should have known psychiatrists are of no help to anybody."

No Easy Answers

It is understandable that individuals in trouble should seek quick and painless ways to ease their discomfort and suffering. It is equally clear that physicians can seldom fulfill their hopes completely.

As in other areas of medicine patients have the right to a diagnostic opinion (what is wrong) and possible treatment methods (what can be done to make things better).

To the extent that one can do this, and the spouses are able to utilize the knowledge, it is helpful to give the information. Early formulations are general and tentative, in most cases, and require further exploration and continued rechecking.

Advice is otherwise a cheap commodity, which both spouses probably heap on each other, and receive from many quarters. The physician's role is not so much to advise directly as to identify areas of arrested development and encourage growth. Many times, though by no means always, this is a slow, unfolding process.

"Show more affection to your wife," "Go out more often," "Take a vacation," "A divorce is the only solution," or "Why don't you get a job?" are not necessarily examples of poor or inappropriate advice in some circumstances, but they probably should not come up very early and certainly not as complete answers to any type of marital difficulty.

Middle Phase of Treatment

Once the couple has gotten started in a joint, good-willed exploration of their problems, they begin to come up with answers of their own. A psychiatrist friend, with many years of experience in this area, likes to say that the counselor ought to be like a magician on the stage. He should perform his "tricks" without the audience's awareness of how it was done.

Though exaggerated, the point is a good one. The more the couple can discover by themselves, with the physician's constant, but unobstrusive support, the more maturity and self-confidence they develop.

After the history-taking of the first sessions, the patterns of interaction through which the partners hurt each other are fairly clear, and hopefully, the way in which this relates to their previous life experiences also becomes apparent. Many times the physician hears the comment, "We were trying to tell each other these things, but we weren't listening!"

The presence of a third party, with equal respect and consideration for both, tends to encourage their abilities to evaluate the problems more objectively and then to experiment with possible solutions.

It is hard work for them as well as for the physician, but as English remarked many years ago.

> ". . . marital harmony is worth as much time, effort and practice as is put into learning a new sport or hobby. This may seem an undignified comparison, but the fact is that people are less prone to exercise their *mental and emotional muscles* than they are their physical muscles."[5]

Termination

After a number of weeks or months of interviews, the couple usually attain a more satisfying adjustment, and they as well as the doctor ma feel that the job is done, at least to the extent tha is needed at that particular point in time. A open-ended type of termination, where the coupl may feel free to return, if necessary, is usually th most convenient.

If the usual sequence of events does not appea or is delayed beyond reason, consultation with more experienced practitioner is, of course, ver wise. A doctor who does a certain amount of ma ital counseling should have consultation available preferably with a psychiatrist he knows well an who is competent in this particular field. In th milder cases the physician may find that talkin things over with the consultant clarifies the situation in his own mind and makes him more efficient in his work with couples.

With more seriously disturbed marriages, th degrees of time, effort, and skill required to brin about the desired changes are so great that direc referral to the consultant after a few explorato sessions may be a better approach.

Equanimitas

The physician's own philosophy of life, as h works with troubled couples, may be his greates asset, provided that it is generally optimistic (without being Panglossian) and realistic (but not unmerciful). In searching for absolute marital bliss or for any other kind of happiness, it is well t heed the wise counsel of Benjamin Franklin:

> "Human felicity is produced not so much by great pieces of fortune that seldom happen, as by little advantages that occur every day."

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Safeguarding the Health Of the Michigan Athlete

The question frequently is asked — "Who is responsible for safeguarding the health and welfare of the student athlete while he is practicing for or participating in interscholastic athletic activities?"

Many answers could be given because many policies, agencies and people are involved. Among such would be state eligibility and contest regulations; state athletic associations; local boards of education; school administrators, athletic directors, and coaches; and student athletes themselves. Members of the medical and dental professions as well as parents of athletes also occupy most important places in connection with these responsibilities.

Each of these categories would lend itself to extensive discussion but this consideration will deal primarily with: (1) Physical examinations of athletes; (2) Conditioning, training rules, playing conditions, and officiating; (3) Limitations of competition; and (4) Legal responsibilities.

Physical Examinations of Athletes

Basic among the regulations for participation in interscholastic athletics in the schools of the nation is the requirement that a student must have successfully passed a physical examination and be certified by a licensed physician who says that, in his opinion, the student is fully able to compete in athletics. This is one of several qualifications that must be met if he is to take part in this voluntary activity. While it is recognized that some of the physical examinations of athletes at times may be rather superficial, the trend is toward examinations which are more complete and all-inclusive.

The medical profession and school health authorities are interested in the development of meaningful physical examination procedures, their record, and follow-up.

The physical examination is for the protection of the student. It should occur within a reasonable time in relation to his athletic competition, at least being taken during a period applicable to the school year concerned. After a serious injury or illness, return to athletic competition should be preceded by an adequate physical examination.

Conditioning, Training Rules, Playing Conditions, and Officiating

Most important in safeguarding the health of the athlete is his being in proper physical condition for participation. The American Medical Association and the National Federation of State High School Athletic Associations have prepared several joint statements on conditioning and health of the athlete which are available for distribution to schools. There is definite documentation that adequately conditioned athletes are less susceptible to injury.

A prime factor in the conditioning area also is the requirement by local school authorities that established training rules be followed by team

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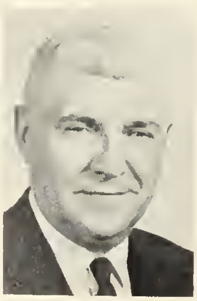
This article was requested by the MSMS Committee on the Medical Aspects of Organized Athletics to acquaint the physicians with the views and work of the Michigan High School Athletic Association. The author was a speaker at the 1967 MSMS Conference on the Medical Aspects of High School Sports.

members. Their value should be impressed upon them by school officials. Often parents and local doctors or representatives from medical groups have worked with school authorities and the athletes themselves in setting up training rules for various sports. Greater values usually are derived from training rules which are the result of cooperative efforts of groups with varied legitimate interests.

Conditions under which athletic contests are played are important safeguards for the athlete. Fields should be free from injury hazards and be smooth with as soft and resilient playing surfaces as possible. Gymnasiums should be clean, well lighted and ventilated, with adequate space between court boundary lines and bleachers or walls. Athletic equipment should afford the greatest possible protection and fit the wearer. Sanitation should be a paramount consideration in connection with wearing apparel, towels, showers, and drinking facilities. Teaching a youngster the importance of sanitation in relation to his health at this impressionable age is a valuable contribution athletics may make. This opportunity should not be neglected.

Associated with "playing conditions" at athletic contests is another most important injury safeguard. For most, if not all, practices and games a physician should be present or on call. It is realized that the presence of a physician in all instances may be impractical but pre-arrangements should be completed so that the school or family physician can be contacted immediately in case of emergency. No one except a physician should treat or move a seriously injured athlete other than his being made as comfortable as possible and the rendering of simple first aid pending the arrival of the doctor.

The importance of the use of properly-trained and safety-conscious contest officials cannot be overemphasized. Training programs, rules meetings, rules books, officiating manuals, sports films, and other training aids are made available to athletic officials by the Michigan High School Athletic Association. The best officials know the rules, keep themselves in good physical condition, know their proper locations on specific types of plays, and realize that many injuries are avoided by alert officiating.



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FORSYTHE

Limitations of Competition

State athletic associations and local school authorities usually are responsible for regulations pertaining to limitations of competition. These involve number and frequency of contests played during a sports season. To some, these regulations may seem arbitrary, but their purpose is the protection of the participant and maintaining a sane balance in the sports program. Michigan has minimum age requirements for certain events in high school track, as well as for the number, distances, and frequency of competition. Swimming has similar restrictions except for age. Basketball and football have participation frequency and number of contest regulations. Tennis has singles and doubles competition adoptions. In wrestling there are weight control regulations. Again, the chief purpose of these limitations of competition is the protection of the high school athlete.

Legal Responsibilities

In Michigan the rules pertaining to eligibility and contest regulations are a part of the Administrative Code of the state. This means that they have the effect of state laws. It is most important, therefore, that they be observed in their entirety by schools and athletes. In the event of non-compliance with them, both as to participation and interpretation, negligence on the part of non-conformists could be a factor in case of an unfortunate incident. As indicated previously, participation by high school students in interscholastic athletics is voluntary. No school should permit students to practice for or compete in interscholastic athletics until they have on file a permission-to-participate card signed by a parent or guardian, as well as evidence that a student has passed a physical examination.

Physicians, coaches, and athletic directors are becoming increasingly concerned about their liability status in connection with the treatment or authorizing play of athletes. Continually, they are cautioned to do nothing other than would be done by a "reasonably prudent person." Sometimes the actions of such a person are difficult to determine. It is certain that coaches should be most apprehensive about their legal responsibility in case of injury to an athlete. Student or faculty trainers should be just that, rather than "amateur doctors," both for their own protection and that of the injured athlete.

Coaches, trainers, athletic directors and other school personnel are always told that "When in doubt, always call a physician."

Generation in Command

BY MILTON R. STERN
DETROIT

The idea of a command, of course, is familiar to medical men. An indecisive doctor never arrives. He washes out as early as an indecisive jet pilot. But if the phrase "Generation in Command" has a high-sounding ring, I shall not apologize. It will be obvious that I don't mean the "Pepsi Generation." In fact, the phrase does not refer at all, either favorably or unfavorably, to teenagers or to people in their mid-twenties. The "generation in command" are the people in their middle years — and to be even clearer about them, the middle years these days extend from about 35 to 65. These are the people who have only themselves to blame if the world doesn't go well, or if life loses its savor. They bear the responsibility so pointedly suggested by Justice Holmes when he said, "The reward of the general is not the bigger tent but command."

COMMAND MEANS decisions — about subway fares and auto safety, about the draft, about war or peace in Viet Nam, how taxes are spent, and who gets taxed. Command means decisions not only by government but by other people — bank presidents, college deans, platoon sergeants, and many of us.

It is true that the young seem always to be in the public prints and on television, but that doesn't mean that they *control* things. To the extent that young people wearing their hair longer or skirts shorter dominate the mass media, they are frequently being exploited for commercial reasons. Youth is used to sell — perfume, cars, cigarettes, and everything else. Youth, indeed, learns to sell itself. What happens to the young people these days is the opposite of commercialized vice — it might even be called commercialized innocence.

Of course, to the extent that their elders, by exploitation, have defaulted, the young may feel obliged to take care of themselves. Some of them have asserted the point by marching with banners into university administration buildings or marching out of commencements. But when they do that, they are pro*test*ants and rebels, not in command, and they recognize the difference and its limitations. They want the people in charge to do better.

Command has a prerequisite of experience that young people these days rarely can have. Some of their elders may lack desirable experience, too. Aristotle once pointed out that there is no such thing as a boy philosopher, but that doesn't mean that every ancient is wise.

Until recently, experience came younger. Alexander ruled the world when he died at thirty-three. John Paul Jones commanded a ship he had bought himself at the age of twenty. Men and women were responsible parents — I emphasize the word *responsible* — before they were twenty.

TWO CIRCUMSTANCES, however, have pushed the general control of society out of reach of younger people. Both are obvious: first, is the rapid development of complex technologies and the growth of an increasingly complex society; second, is the related fact of the longer life span.

The figures are dramatic indeed: As of 1900, a man might be expected to live 48½ years, a woman 51½; today (or as of 1961), a man is expected to live 67 years, a woman 74. So far this has been a Western phenomenon, but it is rapidly becoming world-wide. We are all familiar with the ominous statistics of the population explosion.

Let us return more directly to the major theme — that the generation in command means people in their middle years. With that in mind, I want, in this paper, to speak on three points. First, as life has lengthened, it has become longer, not at the end, but in the middle years. Life has grown longer in the middle.

Second, if we are to be the responsible generation, we may usefully think in terms of all of us, as a group, rather than in terms of somebody else who happens to be a leader, who may have power or accidental publicity. I want to explore a little what it means to be a generation in command.

Third, I want to make three suggestions about how people in those longer, vigorous, middle years can organize educationally to meet responsibilities, that is, to stay in command during their tour of duty, as it were, and not just coast home to early retirement in Florida. "Miami Beach," recently wrote novelist Herbert Gold, "is an extension, adult education course in how to die, pursued with great seriousness by the enrollees." This last point

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Professor Stern is Director of the University Center for Adult Education (Wayne State University, The University of Michigan, and Eastern Michigan University) is an important one for university schools for adult and continuing education, and to you as our students.

Longer In The Middle

Let me go back now to my first point that *life has grown longer in the middle.* The middle years, as such, haven't really been investigated in depth either by social scientists or medical people. Emphasis has been first on youth and then on gerontology, on aging, on the special aspects of the end of life. Middle age has been called a modern invention, but it has been taken for granted. Although increasing numbers of men and women are living out their genetic life span — 80 to 100 years, what has been neglected is that many people are in their *middle* years and that those years have become vastly more productive.

Recent research shows the middle years as more important learning years than had been believed previously. In the humanities and the behavioral sciences, the middle years are, in fact *the* learning years. Mathematics and science can be grasped readily and well by the young, but what about *Moby Dick?* Can anyone really understand it at the age of eighteen? Try re-reading it at age forty with those other assigned books of the first years of college literature courses. Suddenly, you come to understand why they were important. That is why I agree with Sir Eric Ashby, distinguished English educator, who only half-jokingly said that we should give *conditional* university degrees.

Perhaps degrees should be renewable. Just as we require, or should require, older people to show proof of good eyesight before their driver's licenses are renewed, we might require the holders of the B.A. or the Ph.D. to show proof of intellectual vigor before endorsing their diplomas for future use.

MODERN MEDICINE has made the life we live generally more attractive and more pleasant. Chronic ailments begin later, the effects of many disabling diseases are postponed, and in the United States, a high protein diet helps most people attain high energy levels. Thus, life has become longer in the middle. For millions of people the years from 35 to 65 have become an open, healthy time in which great things can be done.

I remember a fine phrase of the late Dorothy Canfield Fisher, novelist and an early president of the American Association for Adult Education. She spoke of the "useful bodies of the middle-aged."

Useful is a key word. It connotes vigor, action, responsibility. Let me note that the universities haven't yet really caught up with the idea of a longer life, particularly its implication for active study and contribution. But I'll get to that a bit later.

Generation In Command

We come now to point number two, the idea that there is a *generation* in command, that everyone in the middle-aged bracket should share responsibility for what happens. Is this just a puritan view contradicting current notions that we are moving rapidly into a leisure society? Perhaps it is somewhat severe, disciplined and, yes, puritan, but I've always thought that Thanksgiving feasting wasn't the only good idea to come out of Massachusetts in 1620. The idea of a shared concern and the taking of individual personal responsibility is central to any notion of leisure that is not simply idiot self-indulgence.

This may be difficult to grasp in a country — ours — whose culture, as represented through the mass media, seems persistently to be dominated by the idea of leisure *as* self-indulgence and of the culture-hero as a know-nothing. As far as movies, television, the popular magazines and press are concerned, America's preoccupation should be fun, and its famous men and women should be shown as idlers. The socially sanctioned function of our celebrities is to be evermore conspicuous consumers. We had better move beyond leisure, at least as presently conceived in the windless world of television, which makes even war into a spectator sport, if we are to find answers that can help us in securing the continuity of our culture.

Organizing Educational Effort

Thus, perhaps obliquely, I come to the final point I want to treat: How can the generation in command *organize its educational effort* to respond to great public questions? These questions of war and peace, of the changing nature of work and leisure because of automation, or relations between races, of crowded cities, of the destruction of the earth's surface, tend to make us feel helpless. They are large and overwhelming.

Can the great questions be reduced to human size? This is a major imaginative task of education. I think a good part of that task remains to be done. In many ways, the universities themselves need to be persuaded, as our students have been already, of the importance of adult education. Many institutions engage in programs absent-mindedly, not realizing their implications. It is not that the academic brethren are wrong-headed so much as that they haven't thought about adult education. To the extent that they are educators and not specialists, they should.

I am persuaded that *time,* the idea of time, is a neglected dimension in all education, particularly n higher education. Texts galore, texts and tomes and articles in the *Saturday Review* are written on he work of universities. Rarely do they go beyond graduate study and its ramifications in their coneption of what the purposes of a university might nclude. And yet there are four to five times as many adults going to classes throughout the country as there are young people in college today.

Time — when one might be a student — is the neglected dimension. The question of *who* shall be educated is discussed widely, the question of *what* shall be taught agitates all kinds and conditions of people, but the issue of *when* people shall be taught — even throughout life — this is considered very rarely. If it were, it might involve drastic changes.

IN ANY CASE, the real educational needs of the generation in command tend to be ignored by most universities. Most of the time, even if done well, translations of college or even high school instruction have been attempted. But a conception of curriculum built on earlier educations as a guide for men and women in their middle years — perhaps a *thirty- or fifty-year program of study* or pattern for living — has not been developed.

I don't think this is a rash proposal. To go from nursery school through undergraduate years through the baccalaureate already takes eighteen years. Moreover, cradle-to-the-grave education has been accepted as a reality for themselves by university faculties. By and large all the competent academic people I know show their belief in continuing education by acting upon the belief. That is, the good professor is not only a learned but a *learning* man who studies all his life. What works well for him should be good for others.

Imperatives

I spoke of three suggestions. My first injunction is to my *university* colleagues: They have an obligation to develop for other people — adult students — programs of study as good as those that have been useful to them personally. Their neglect has been inadvertent, but no less serious on that account.

My second imperative is to students in their middle years: Do not take as given, and without consideration, university programs of study which may have been conceived offhandedly and without you in mind. I do not exempt my own institution, my colleagues or myself from your critical judgments.

We are only at the beginning of comprehensive planning in the field of university adult education, whether in the liberal arts and sciences or other fields. The opportunity for a community of learning is a genuine one when we consider that the living experience of both teacher and learners is similar. One can understand that a faculty would feel somewhat out of touch with twenty-year-olds. But with thirty-, forty-, and fifty-yearolds, frequently of good educational background, the situation is different.

THIS RAISES A third assignment of work for another group, this time for me and my colleagues in the field here and in the country: We should invent the machinery whereby students can share more actively in program-planning and curriculum-building. So far, this has been accidental and episodic. To organize our field of university-level adult education professionally and without the involvement of our students in this way will be to leave out the vital ingredient. This is a task which, as I hope I've made clear, presents an opportunity for a shared experience of education in which teaching and learning are as one and which goes past the classroom.

That students might share in the governance of our institutions is, in fact, in a great tradition. It goes back to the student universities of medieval Italy. At Bolgna, for example, in the thirteenth century, the masters and doctors of the university had to get permission from the students to go on vacation. I think that the matter of involving students not only as classroom learners but as planners with their teachers is a major unfinished business of adult education in universities. Community-centered schools for adults have been modestly effective with communities and councils of advisors, but this has been necessarily *ad hoc* and episodic. For university schools, on the other hand, student-faculty community can be much more than a sentimental gesture; it can be a major change of outlook, bringing in its wake vital changes in methods of teaching and learning and of the planning of programs.

The continuing education of professionals is rapidly becoming a major part of university learning. It offers an ideal opportunity for student-faculty rapport. For example, medicine can best be served by peer-group learning methods, seminars and workshops.

THE DEVELOPMENT of continuing, post-degree education is already significant in many fields. The medical profession, in collaboration with imaginative adult education, can pioneer not only to improve itself but also establish a pattern for other professions.

I would end by saying that, as all of us use the opportunity of the middle years — as life has grown longer in the middle — we can, indeed, become a Generation in Command.

Rising Health Costs: A View From the Congress

BY REP. WILBUR MILLS, CHAIRMAN
WAYS AND MEANS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

(Editor's Note: Congress, professional associations, voluntary organizations, federal agencies, etc., are all studying carefully the many addresses given at the recent National Conference on Medical Costs in Washington, D. C. The AMA News *has carried excerpts from the various speeches. Following is the complete address by Representative Wilbur Mills.)*

The problem of rapidly rising health costs is well worth the attention of all Americans.

One of the most difficult tasks faced by a member of Congress is that of weighing demands and the needs of people for the benefit of various legislative proposals against the capacity and willingness of the taxpayers to pay for them. Those of us who serve in the Congress are at the point of decision in this process; the buck stops with us, so to speak.

We must not only consider the ability of the taxpayer to finance an otherwise desirable program, but we must also weigh the benefits and costs of the legislation in question against the demands and need for other improvements in social welfare, in defense, in education, in health and in the many other areas that compete for available funds. And the Congress must always be alert that the funds entrusted to it are used effectively and efficiently.

PRESENT CONCERN in the Congress over the very great increases in health costs stems from this responsibility. And, ladies and gentlemen, Congress is concerned.

We know that the issue is not whether health is important or whether health care deserves support.

The question which concerns the Congress, and which is the subject of this conference, is whether the increasing sums being spent on such care are being spent wisely and efficiently. Are the people who pay for health care through insurance premiums, and taxes, and through out-of-pocket expenditures, getting their money's worth? And are our tax and private resources being used to best advantage?

As you know, an overwhelming proportion of all of the nation's hospital beds are in nonprofit and government hospitals, reflecting an almost complete absence of private competition. Many of the country's health care expenditures are financed by government or such nonprofit programs as Blue Cross and Blue Shield. In essence, then, some of the largest components of the health services industry are insulated from many of the competitive market place conditions applying to private enterprise generally.

AS YOU KNOW, TOO, the role of government in the health field is a rapidly growing one. There are federal programs to help train professional and subprofessional workers of many types in the health field. There are federal programs to help with the construction and purchase of capital equipment for hospitals and other types of facilities, and there are loan-guarantee programs for nursing homes. And there are many other federal programs.

We have now had about one year's experience with the Medicare program, which at this time is purchasing over a quarter of all general hospitals days. Moreover, as the Medicaid programs under Title XIX of the Social Security Act are put into effect in more and more states, the proportion of hospital days paid by government will increase well beyond present proportions.

"The basic Medicare decision was to use the private sector."

Perhaps one of the most important things to keep in mind about these federal programs is that the manner in which they are devised represents a basic decision that the health industry in this country should remain in the private sector. We have, as a nation, decided not to follow the path of many other nations in recent decades by nationalizing the health industry. This basic decision, to use the private sector with cooperative arrangements between government at all levels, private industry and nonprofit association, has very important ramifications. It gives us many advantages over the more rigid systems used in many other countries. It fits in well with the kind of experimentation and creativity which, I am sure, will mark this conference.

This basic decision means that all of us must give continuing attention to the need to make all the parts of this pluralistic system work as smoothly as possible.

THE SPECIFIC SUBJECTS with which you are dealing here are not unknown to the Congress and especially to the Committee on Ways and Means. After all, there were pending in Congress some forms of hospitalization for more than a decade before Medicare became law, and some consideration had been given to them. At the time the Committee on Ways and Means met in executive session in 1965 to work out the provisions of the Medicare program, we had the benefit of numerous public hearings and months of previous executive session work on the general subject. We reviewed very closely the cost estimates submitted by administration officials. We were aware also that the administration's estimates had been revised substantially upward over the years, primarily as a result of our prodding.

"Expected hospital wage rates to catch up."

After our review and after the benefit testimony from experts in the hospital and health insurance fields, the Committee adopted new and more conservative financing assumptions. For example, we increased the administration's utilization rate assumption by 20 percent. Incidentally, the Committee was probably correct in increasing this assumption; experience so far appears to have closely matched the estimates.

We knew that hospitals costs were going up rapidly and we knew they would continue to go up rapidly for many years. We knew that hospital wage rates were low and were going into a catching up period. We knew that many new medical procedures, involving the use of expensive equipment would continue to be developed. And, on the basis of the best advice available at that time —both from the governmental and private sectors— we wove these factors into our cost assumptions.

We also included provisions in the legislation designed to prevent over-utilization of hospital facilities without involving the government in day-to-day hospital operations. The hospital utilization review mechanism is, as you know, operated by the hospital itself. Moreover, benefits were provided for low-cost alternatives to inpatient hospital care so that the doctor could recommend care in the hospital outpatient department or an extended care facility or a home health program knowing that the care was covered.

All these factors were taken into account in preparing the cost estimates used by the Committee. The Congress enacted a contribution schedule which, it was then expected, would yield income sufficient to meet payments over the 25-year period covered by the estimates.

The Committee on Ways and Means earlier this year received testimony that hospital costs have gone up and will continue to go up even faster than was anticipated by our governmental and private sector advisers in 1965. The American Hospital Association gave us testimony this year which indicated that hospital costs will have gone up 30.2 percent in the two-year period ending October 1967 – well above the increases assumed in the estimates. The Consumers Price Index shows that hospital room charges have gone up *21 percent* over the year that ended in April. The very large increases in hospital costs will have to be considered very carefully in deciding whether some adjustment in the tax schedule supporting Medicare needs to be made. At this precise point in time, I doubt that we have enough information upon which to make an informed judgment. We hope more definitive data will soon be available to us.

"Ways and Means Committee will continue to keep Medicare on sound basis."

BUT LET ME ASSURE you that the Committee on Ways and Means and the Congress will continue to act responsibly. We will take whatever steps are necessary to assure that the Medicare program will remain on a fiscally sound basis.

This is not to say, however, that the Congress or the nation will continue to accept constantly increasing hospital costs without asking some searching questions.

It is a hopeful sign that the public, insurance organizations and the many other private and public groups which purchase medical services are becoming aware of the need to take a new and critical look at health costs. I find it particularly reassuring that people of your caliber, people from fields of voluntary endeavor, are meeting to discuss these critical matters openly and frankly. As I have indicated, federal legislation with which I have been directly concerned has placed primary reliance not on government controls to achieve quality and economy in health but in the people who are responsible for our voluntary system of medical care — the people at the local level who make the system work.

Some of the questions which people will ask are quite obvious even to the rather casual observer of the hospital field. For example: Are hospitals and other providers of medical care using the most modern business methods? Are the funds being spent for acute short-term beds or maternity or pediatric beds in areas where the true need is for long-term beds? Are too many extremely expensive installations for open-heart surgery being made in the same area? Is the question of whether to get new equipment in a hospital in too many cases resolved in favor of prestige rather than carefully assessed need? Has the art of local health planning developed to the point that we are sure it is the most useful device to meet the problems we are concerned with?

FRANKLY, I DO not want to see government agencies intrude more into this process. I believe we can depend on hospitals, operating individually or through local planning agencies, to exercise the restraint and good judgment necessary to meet these problems. But these are important questions; and there are many others.

"Can we stretch the health dollar and also raise standards?"

Perhaps the most important question underlying all the rest is, can we stretch our health care dollar and at the same time raise our standards? I believe we can. There are tools and procedures which have been found effective in the business world that may not have been fully used in many areas of the health care industry. I would urge that the health services industry accept as an important, deliberate goal in their everyday planning the application of these tools with creativity and with a willingness to experiment.

SOME PEOPLE HAVE SUGGESTED, for example, that there are a large number of possible computer applications in the hospital field. Over 30,000 computers have been installed by businesses since the installation of the first commercial computer in 1951. But we are advised that the application of computers in hospitals has as yet made little progress. Business has clearly demonstrated the benefits that can be achieved from the application of automatic data processing to such activities as quality control, inventory control, fiscal management, making payrolls, scheduling and routing and record maintenance.

We are told that at least 15 percent of a hospital's expenditures are on administration and recordkeeping. These functions can, I hope, be made more efficient through expanded use of computers. We are also advised that computers can also help to improve patient care. Computer applications have been found worthwhile in such a delicate area as the detection of sudden changes in pulse and respiration during brain operations.

Obviously, no patient can be properly cared for without the personal contact of nurse and doctor. But nursing care accounts for only one-fourth of a hospital's costs. As you know, much of the work is in food preparation, laboratory operation, laundry, plant maintenance, and other activities which might well not only be done less expensively but better if automated. The automatic laboratory is in existence in some few hospitals.

IN ADDITION TO automation, other techniques of modern management must be examined for possible application to hospitals. Principles of scheduling developed in business may have broad application to hospitals in such areas as the reduction of the time between steps in providing care and in maintaining inventories at the minimum efficient levels.

"Hope hospitals will improve accounting systems."

I hope, too, that hospitals will do much more to improve their accounting systems. Businesses generally make certain that they know how much it costs to produce each item of service; I see no reason why hospitals should do any less.

I hope, too, that hospital organizations will work toward the development of reliable measures of hospital productivity and quality. It seems clear that we cannot evaluate the steps you are discussing without adequate measures of their effectiveness.

Now, I realize these things I am discussing, of course, may have little — or at least less — applica-

Michigan physicians will find the color and bright lights of Houston spectacular while they are in the Texas city for the AMA convention, November 26-27. Visitors viewing the downtown area will find it difficult to realize that Harris County, which includes Houston, also has more cattle than any other county in Texas.

RISING COSTS: Continued

tion in the small hospitals. But some still apply there.

I hope that all of you here who can contribute to the goal of more efficient service continue your attention to it long after you leave this conference. I know of the sense of mission which so many in the health field bring to their jobs and I am sure that that dedication will lead to much progress being made over the next months and years. I do not expect, and I am sure the Congress does not expect, that hospital costs will go down. But we need to work very hard to keep the increases as low as possible, consistent with high quality care.

"And in conclusion . . ."

The challenge which we face in dealing with rapidly rising health costs is complex and susceptible of no one solution or even several easy ones. But it is a challenge we must face — with intelligence, with a spirit of cooperation, and above all with determination to make real progress. With the opportunity for inventiveness and for experimentation which are the blessings of a free society, I am confident that progress will be made. You may be sure that the Congress will be watching your efforts with great interest and concern.

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BY MILFORD O. ROUSE, M.D.
AMA PRESIDENT

Who Makes AMA Policies?

If you watch television news, listen to radio commentators or read newspapers and magazines, you are almost bound to run into the occasional statement that such-and-such an idea is "the policy of the American Medical Association" . . . or perhaps it is referred to as a policy of "organized medicine" . . . or maybe it is simply called a policy of "the medical profession."

It might have occurred to you — and from letters that come to the AMA, we know it has occurred to others — to wonder just exactly how some idea, some program, does become policy of the medical profession of the United States. In other words — who says this thought will be AMA policy?

Some people probably envision a very simple process in which a man — perhaps the president of the American Medical Association — issues a memorandum telling doctors what to believe, what to say, what to do or what to think. Others perhaps imagine a much more complex and difficult system whereby all of our nation's more than 300,000 physicians are asked to give their individual views on given issues, and only the unanimous opinions become statements of policy.

Neither of these is right, I'll assure you.

As I explain how AMA policies are developed and adopted, I will use several terms synonymously — organized medicine; the medical profession; and the American Medical Association. I do so because to a great extent, although not entirely the three are the same.

The American Medical Association is the principal organization of doctors of medicine in the United States. I believe it is not immodest to say it is the principal organization of doctors of medicine in the world today. It has as members something over 70 percent of the physicians in this country, including those in practice, in research in medical education or in any other line of endeavor connected with their profession.

First, however, let me give you some examples of medical policy.

It is, for example, the policy of the American Medical Association that careful, continuing study should be made of the subject of insanity in this country.

It is the policy of the AMA that the office of coroner should be reorganized to eliminate the evils existing in having coroners' inquests conducted by incompetent persons . . . and that any person appointed to the office should be a reputable physician.

It is medical policy that inebriate asylums should be established where victims of intemperance could receive treatment.

It is medical policy that every public hospital for the insane should have one or more consulting physicians.

And, as a final example, it is the policy of the American Medical Association that the chronically insane should not be put in jail, but should be provided with accommodations in connection with, and under the supervision of, a hospital.

I don't expect that any of those statements jarred you. I'm sure you are thinking to yourself that being in favor of those ideas is about as con-

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(Note: This article is the speech presented by AMA President Rouse this term at a Wayne State University School of Medicine Assembly. The article has been condensed some by eliminating some details about the AMA history and procedures.)

roversial as favoring motherhood, the flag and hanksgiving.

Viewed in the light of our world today, I agree with you. But in their defense, I would like to point out that every one of them was adopted 100 years ago or more by the AMA. And I have no doubt that every one of them was considered revolutionary and radical in its day.

THROUGHOUT ITS HISTORY, which now goes back 120 years, the American Medical Association has been coming up with ideas like those . . . has been carrying out programs through medcal societies and in cooperation with every coneivable kind of organization . . . and has been ecommending state and national legislation, where necessary . . . all designed to carry out the purpose for which the Association was established.

That purpose is stated in only 20 words in Article Two of the AMA constitution: "The objects of the Association are to promote the science and art of medicine and the betterment of public health."

DURING ITS 12 DECADES, the Association has developed a great many different policies. Not all of them have met with immediate public approval. Some have seemed to go directly counter to public opinion. But such a disadvantage has never stopped the Association from continuing its drive to improve, in every way possible, the health of the citizens of the United States.

The plan of organization adopted by the AMA is described in Article One of its constitution: "The name of this organization is the American Medical Association. It is a federacy of its state associations."

The federation approach, actually modeled on the government of the United States, was chosen as the only practical and workable system of organization. A dictatorship, by one man or a small circle of leaders, would not be any more successful for physicians than it has been for the people of nations unfortunate enough to have it. On the other hand, a pure democracy becomes totally unwieldy as soon as membership or population grows beyond the ability to put all of the voters into a single room for a meeting.

Consequently, the founders of the AMA, like the founders of our nation, established on the national level a congress, or legislature of medicine. It is the House of Delegates of the American Medical Association.

Members of the House are elected to their post by their colleagues and represent their constituents in the same way members of the national congress represent the citizens of their district or state. It is the resolutions and reports passed or adopted by the House of Delegates that become the policy of the AMA.

YOU MIGHT ASK at this point whether every physician agrees with every policy of the House of Delegates. I would reply by asking a similar question: does every citizen of this country agree with every policy of congress?

Certainly the actions of the House of Delegates represent the majority opinion of the physicians of our country, since each delegate was elected by the physicians of his state.

The process begins at the county medical society level where members elect representatives to the state association House of Delegates. The state associations, in turn, elect members of the national House.

Each state is entitled to one national delegate for every 1,000 member physicians or portion thereof. You see, therefore, that delegates to the House were elected by state representatives who were, themselves, elected by their county societies. We have not been able to devise a system that is more democratic than that.

The House meets twice a year, during the two conventions of the AMA. The annual convention, held in June each year, is the largest and most important medical meeting held anywhere in the world.

In addition to convening the House of Delegates, the convention includes an exhaustive scientific program. Hundreds of papers are presented, plus motion pictures, scientific and industrial exhibits, and closed-circuit television presentations.

The second meeting of the House each year is in November, as a part of the AMA's clinical convention, which is also a complete scientific program, although somewhat smaller in scope than the annual convention.

Prior to each meeting of the House, state associations, the AMA Board of Trustees and the standing committees of the House submit reports and resolutions for consideration of the House.

Each resolution and report is introduced to the House and sent to a reference committee, which holds open hearings at which any AMA member is free to testify for or against the idea. Reference committees are appointed for each convention in order to give as many delegates as possible a chance to serve.

After the open hearing, the reference committee meets in executive session and issues a report to the House, supporting or opposing the item, based on the committee's own views and the testimony presented on the matter. The Committee report is then debated in the House and final action is taken. Every item that is passed becomes the stated policy of the House of Delegates.

IN THE ANNUAL CONVENTION this year, the House and its reference committees considered and heard testimony on 151 items of business. Included were 123 resolutions from the state and territorial associations . . . 18 reports from the Board of Trustees . . . and 10 reports from the standing committees of the House, which are the Council on Medical Service; the Council on Medical Education; the Council on Constitution and Bylaws; and the Judicial Council.

What were some of the items passed by the House?

Many of them have to do with major, long-range programs involving the cost of health care, the education of physicians and allied health personnel, the participation of physicians in government medical programs and the over-all relationship between private practitioners of medicine and the federal government.

It is in the area of helping to improve the health, the health care and the health conditions of individual citizens that the AMA, through the years, has made its greatest and probably its most unrecognized contribution.

WE DON'T SEEM TO GAIN much favorable attention for the hundreds of things we have accomplished in 120 years to make your life better. But we get a lot of publicity when we oppose some federal health program that our House of Delegates sincerely believes is not in the best interests of the public we serve.

Legislative activity is a minute part of our overall function. But it is an important part. We believe that our obligation to promote the science and art of medicine and the betterment of public health is served when we support what we consider to be good legislation, and when we oppose what we consider to be bad legislation.

If some of our severe critics took time to check the record, they'd find the AMA has supported a great deal more legislation than it has opposed.

Examining that record would show that it is to a high or moderate degree through the actions of the American Medical Association that you are protected by food, drug and cosmetic laws . . . that vitamins and minerals are used to improve the nutritive quality of foods . . . that milk is fortified with vitamin D . . . that you have enriched flour, iodized salt, fruit juices with high natural levels of vitamin C . . . and canned baby foods.

In 1871 it was the AMA that urged establishment of state boards of health. In 1912 it urged the establishment of a department of health in the president's cabinet. It also recommended creation of the U.S. Public Health Service and the Federal Food and Drug Administration.

And long before the current furor began — back in 1954, in fact — the AMA recommended to automobile manufacturers that they consider equipping all cars with safety belts, and that they give increasing emphasis to safety in the design of all cars.

You and your family might not think about the AMA very often, but you benefit every day from actions taken by the Association through the years. And that benefit for you, even through unseen and unacknowledged, is our reason for existing.

To repeat our objective one more time, the AMA was founded in order to promote the science and art of medicine and the betterment of public health. Every policy established by the House of Delegates contributes to that objective in one way or another, whether it is to raise the standards of trainers who teach your children to play a sport, or to improve the standards of education and training of physicians.

THE FACT THAT THE AMA has made its contributions to the health and well-being of the people of our nation for so many years is one of the major reasons why life expectancy, that was only 47 years at the turn of this century, now stands at slightly more than 70 years.

And it is one of the big reasons why many of the dread diseases that used to cripple and kill our children and adults — scourges like tuberculosis, diphtheria, typhoid fever, cholera, smallpox and polio — are almost unheard-of today.

Milford O. Rouse, M.D., new AMA president, talks with newsmen after his speech to the junior class at Wayne State University Medical School.

Suggests Many Community Projects "Just Waiting to Be Hatched"

(The following comments will be of interest to physicians and their wives in their community-service work. These comments are excerpted from an address by Howard J. McCluskey, Ph.D., University of Michigan Professor of Educational Psychology and a national authority in community development and adult education.)

"All communities, even very good ones, have problems. These problems may come and go and return again, or they may pop up unexpectedly for what appears to be the first time. But problems and difficulties there are — a continuing part of community living.

Fortunately in most communities, these difficulties could be managed, if not eliminated, by setting up projects which are just waiting to be hatched. They are latent. They are already on the back burner of the mind of some interested person, or in the plans of an organization. They need only to be packaged, explained, and pushed.

THEY WOULD BE GENERALLY, if not enthusiastically, welcomed by the community if someone would take the trouble to work on them.

Take better services, better adult educational programs — no one is really against recreation, cleanliness, good health and education. These are the unfinished business of community improvement.

Inertia is their principal enemy.

Communities also have problems which are less innocent. They may be sleeping or active, but if not properly handled may generate more conflict than cooperation, and more heat than light. These too can be converted to constructive community improvement if some person or group will take the initiative to break the log jam of apathy.

Every year, Professor McCluskey conducts many workshops with varied organizations about ways to increase participation in the identificaton and solution of community problems.

WHAT CAN BE DONE?

A strategy of action for community improvement will vary according to what the community hopes to accomplish. In any case, whatever the goal and however complicated the procedure, organization for projects of community improvement may be thought of as going through three more or less overlapping stages — talk, study, and action.

Who initiates the talk?

Anyone and any group. The initiator must share the succeeding steps of initiation with others. The talk-stage is one of discovery where common concerns are informally shared.

Sometimes talk seems to be the only thing that happens. Many times, however, a key conversation between key people plants the seed for later achievement. Every project for community improvement has a history, and the first chapter of that history is a story of talk.

But the talk-stage must be soon followed or paralleled by study. Fact-gathering is a necessity. It is important to know what other people have done with similar problems, and to know the specific nature and scope of the problem in one's own community. Often the facts are already known — it's a matter of collecting and interpretation.

Most people are not content with just talk and study.

TO THEM, *ACTION* IS the major justification for a concern with community improvement. The action-stage should involve the assistance of agencies which have significant action to contribute to the solution of the problem. In other words, it is important to secure the collaboration of agencies and persons whose on-going programs contain resources for the solution of problems under consideration.

Peaks and valleys are to be expected in the course of community work. The 'honeymoon' period is a peak of initial achievement and enthusiasm, but this is no reason to be discouraged. Real change is possible; what other communities have done confirms this. So much has been accomplished with a little effort. How much greater our accomplishments would be if the effort were expanded and sustained."

State Chamber Boosts World Trade Program

BY HARRY R. HALL, PRESIDENT
MICHIGAN STATE CHAMBER OF COMMERCE

Convinced that the expansion of Michigan's foreign trade in agriculture, business and industry is of vital importance, a World Trade Program was recently inaugurated by the Michigan State Chamber of Commerce. Active membership participation will be featured.

Donald R. Mandich, Vice President and Manager, International Banking Department, Detroit Bank and Trust, is Chairman of the new World Trade Committee. Utilizing the services of a World Trade Advisory Council, the committee will function under the staff guidance and direction of Mervyn V. Pallister, Manager, World Trade Department. Immediately prior to his recent retirement from the Foreign Service of the United States, he was the American Consul General of Curacao, Netherlands Antilles.

A general membership announcement about the World Trade Program brought enthusiastic and gratifying response. About 80 members have already opted for service on the World Trade Committee, and the number is growing steadily.

THE STATE CHAMBER has embarked upon this new project because American businessmen, long familiar and content with serving the world's most affluent market right in their own backyard, are awakening to the fact that additional advantages can accrue to them by expansion to world markets. Many are now successfully buying and selling abroad.

This story is best told by the nation's impressive trade statistics. *Exports* of U. S. merchandise in 1966 hit a record $29.4 billion, up 50 per cent from $19.6 in 1960, or an increase of 194 per cent from $10.0 billion in 1950. *Imports* of merchandise in 1966 were valued at a record $25.4 billion, up 73 per cent from 1960 or about 183 per cent from $8.9 billion in 1950.

This upsurge, however, should not obscure the fact that most American businessmen are a long way from attaining their true potential as world traders. Today, we still export less than 6 per cent of our gross national product — a low percentage for any major industrialized nation. A relatively small number of firms, some 3,000, account for more than 75 per cent of the total U. S. export dollar. Our performance can and should be better.

IN THE YEARS ahead, rapidly rising income abroad will result in world-wide demand that should grow at an unprecedented pace. The emergence of the European Economic Community (The Common Market) and the European Free Trade Association is creating new markets comparable to our own market at home.

The recent Kennedy Round of negotiations culminates a multilateral effort of more than four years. The United States and 52 other countries agreed to recommend tariff reductions through 1972 averaging 35 per cent on industrial goods and to substantially smaller cuts in duties on farm products. Some $40 billion of world trade, involving 5300 products that represent 80 per cent of world trade, will be affected by Kennedy Round concessions. Between $15-16 billion of U. S. trade will benefit. This is about equally divided between exports and imports.

The trade barriers which fell at Geneva clear the way for greater advance in mutual trade. World trade will expand faster in response to the lowering of barriers; manufacturers will have less cause to set up production facilities inside foreign national or regional tariff walls; aggressive sales campaigns will break out as the terms of competition become more nearly equal between national producers and importers of foreign goods. Any businessman who ignores this improved world market is betting against the future tide of history.

EXPORT SELLING has acquired a reputation for being difficult. When thought of as a logical extension of domestic practices, however, much of the mystery disappears. Industry, the financial community and the U. S. Government have united in a massive effort to help you start or expand overseas market operations. The competition for these markets is generally keen, but if State Chamber members accept the challenge abroad as well as they have accepted the challenge of domestic competition, the rewards will be most satisfying. The results will aid not only the earnings of individual members, but the economies of their communities, the state and the nation.

et's be specific about Campbell's Soups...
and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Campbell's
CONDENSED
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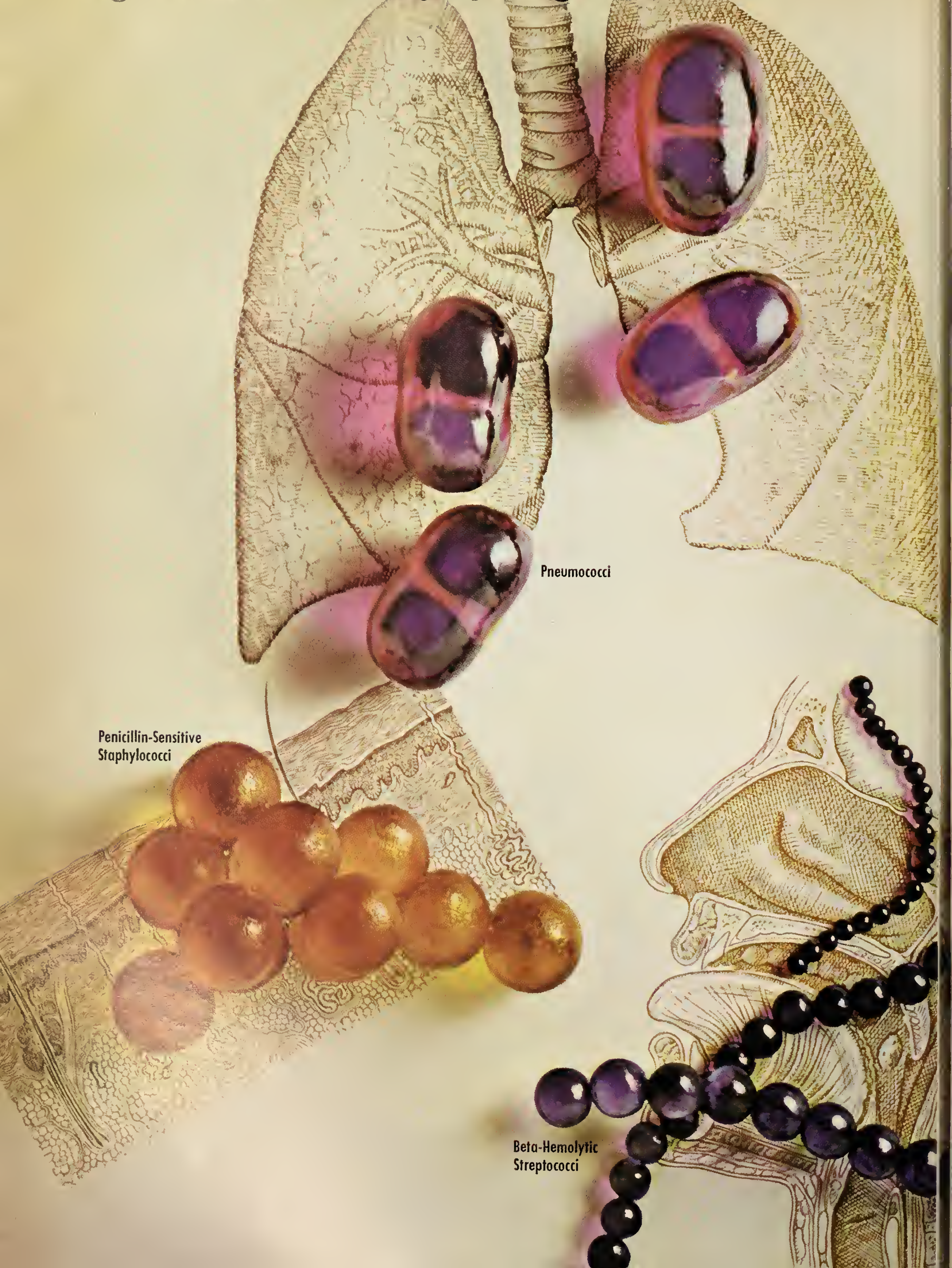
Against these three major pathogens…


Pneumococci
Penicillin-Sensitive Staphylococci
Beta-Hemolytic Streptococci

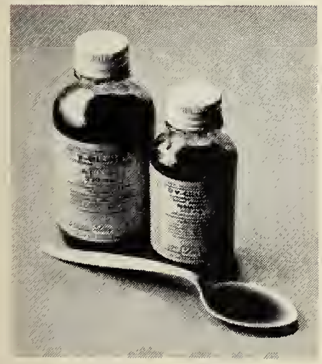
V-Cillin K® provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.



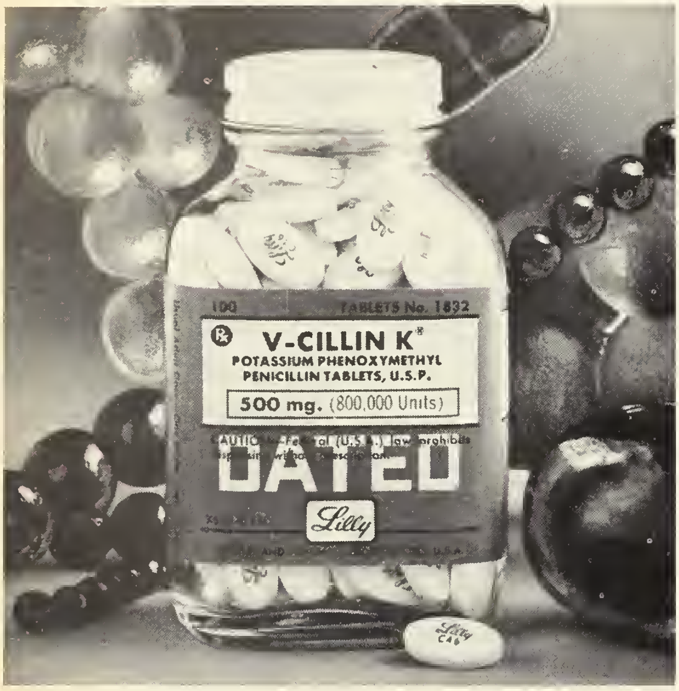
V-Cillin K® Lilly 701297

Potassium Phenoxymethyl Penicillin

Now available: V-Cillin K®, Pediatric, for Oral Solution, 250 mg. (400,000 units) per 5 cc. of solution.

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly wit parenteral dosage schedules, frequent evaluation of the ren hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgra pencillin-insensitive organisms. In such cases, its administration be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are mu common with administration of oral penicillin than with intram forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a cant index of sensitization. The following hypersensitivity re associated with the use of penicillin have been reported: skin ranging from maculopapular eruptions to exfoliative dermatiti caria; and reactions resembling serum sickness, including chills, edema, arthralgia, and prostration. Severe and often fatal anap has occurred (see Warnings). Hemolytic anemia, leukopenia, bocytopenia, and nephropathy are rarely observed side-effec are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-C Pediatric, the usual dosage ranges from 125 mg. (200,000 units) times a day to 500 mg. (800,000 units) every four hours. For i the daily dosage may be 50 mg. per Kg. of body weight divide three doses.

Beta-hemolytic streptococcus infections without associated teremia may be treated with 200,000 to 400,0000 units three ti day. Therapy should be continued for a minimum of ten days to p development of rheumatic fever and/or other serious complic Dosage for routine streptococcus prophylaxis in patients with a of rheumatic fever or congenital heart disease may be 200,00 once or twice daily. When such patients undergo tonsillectomy, extraction, or other minor surgery, the prophylactic dose sho 500,000 units every six hours given two days prior to surgery a two days postoperatively. If oral medication is not feasible on th of surgery, parenteral therapy should be considered. Mild to m ately severe pneumococcus pneumonia has been treated effe with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be every six to eight hours in conjunction with indicated surgical dures.

For gonorrhea in males, 500 mg. (800,000 units) every four ho three doses may be employed; in females, 500 mg. every four for six doses are recommended. Refractory infections generally re to a second treatment three to four days following completion first. Treatment of gonorrhea with severe complications shou individualized, with prolonged and intensive treatment. Patients suspected lesion of syphilis should have a dark-field examinati fore receiving penicillin and monthly serologic tests for a minim three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 uni bottles of 50 and 100; and 250 mg. (400,0000 units) and 50 (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [0

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Cites FDA Problems Facing Drug Firms

It is not unusual to have one of the pharmaeutical firms cancel its scheduled advertising in *Iichigan Medicine* because of problems with the ederal Drug Administration. The FDA rules and egulations, from time to time, get sticky.

The situation was explained well recently by . Joseph Stetler, President, Pharmaceutical Manuacturers Association, before the AMA Medical Soety Executives conference recently in Chicago.

In part, Mr. Stetler declared:

“Advertising in all its ramifications has become favored target of enemies of the free enterprise stem, and of certain fuzzy-minded souls who are mply enemies of advertising per se. You are painlly familiar by now with the denunciations eard over and again in the industry, ad agencies nd medical journals. Unlike other consumer inustries, we must be constantly on our guard to ard off the destructive effects of these attacks beuse we are a regulated industry.

“We know that when the advertising of one of ur member firms fails to fit the notions of someody in the bureaucratic hierarchy, the firm is ubject to punitive action by the government. Isuance of the new regulations by the FDA now dds more fuel to the fire.

“Speaking of the drug industry, let me assure ou that we recognize that the FDA performs its uties under trying circumstances. In many ways, seems to us, the agency's assignment is imposble of fulfillment for the plain and simple reaon that the job is too enormous. There are just ot enough scientists and skilled experienced peronnel available to the government to monitor the ctivities and products of the 1700 drug manufacurers that are scattered across the country today.

“Bear in mind that only 140 of them are members of the PMA producing 95% of the drugs on e market. These are research-oriented, quality onscious firms who know the business and are roud to be identified with their products. The ther 1560 companies produce 5% of the drugs. hey include the imitators, the opportunists, the ady operators and worse, producers whose qualications consist of equal parts of faith, hope, and norance. Who they are, precisely, where they ake their products, under what conditions, with hat safeguards, simply is not known to the FDA r anybody else with any certainty.

“The difficulty is there are two separate and disnct drug industries in the United States at the resent time. There is the reliable manufacturer ho values highly his name and reputation, and who strives to maintain the highest standards. For him, there is a built-in desire to excel in product quality as a competitive measure. This is the patient's strongest safeguard.

“There is, at the same time, a least conscientious manufacturer who has no name to protect and who is interested in quick profits and little else. He represents an element in the industry which should be eradicated.

“Yet the wholly false premise which has been planted in the public minds is that adequate safeguards do exist — inspections, testing, etc. — which assure that one drug is as good as another regardless of their source, else they would not be on the market. We know this is not true. To expect a government agency to guarantee that every product reaching the public is of high quality is to expect an obvious impossibility.”

Dow Demonstrates Blood Chem Testing System at G.R.

A compact system for blood chemistry tests to be performed in the physician's office or industrial medical laboratory is being introduced to Michigan physicians by the Dow Chemical Company.

Dow said the system uses new and simplified techniques that produce accurate results in 30 minutes or less with premeasured reagents. They were developed by clinical chemists of the Dow Human Health Research Laboratories at Zionsville, Indiana, and Bio-Science Laboratories, of Van Nuys, California.

The system was demonstrated to physicians attending the Michigan State Medical Society meeting September 24-29 in Grand Rapids.

John Di Giorgio, Ph.D., Development Director of Dow Diagnostic Products, said available tests include hemoglobin, glucose, urea nitrogen, cholesterol, and uric acid. Others are in “advanced stages of development and testing.”

All of the equipment and reagents necessary require only the space of a table. Elapsed time for testing ranges from five to 20 minutes.

Director Di Giorgio said accuracy and simplicity were the research objectives. He added that the response by clinicians has been excellent. “We believe the system will benefit the doctor and be convenient to his patient,” he said.

The test for determination of hemoglobin is done with whole blood. Others use plasma or serum. Each involves premeasured liquids which eliminates or reduces the need to transfer reagents.

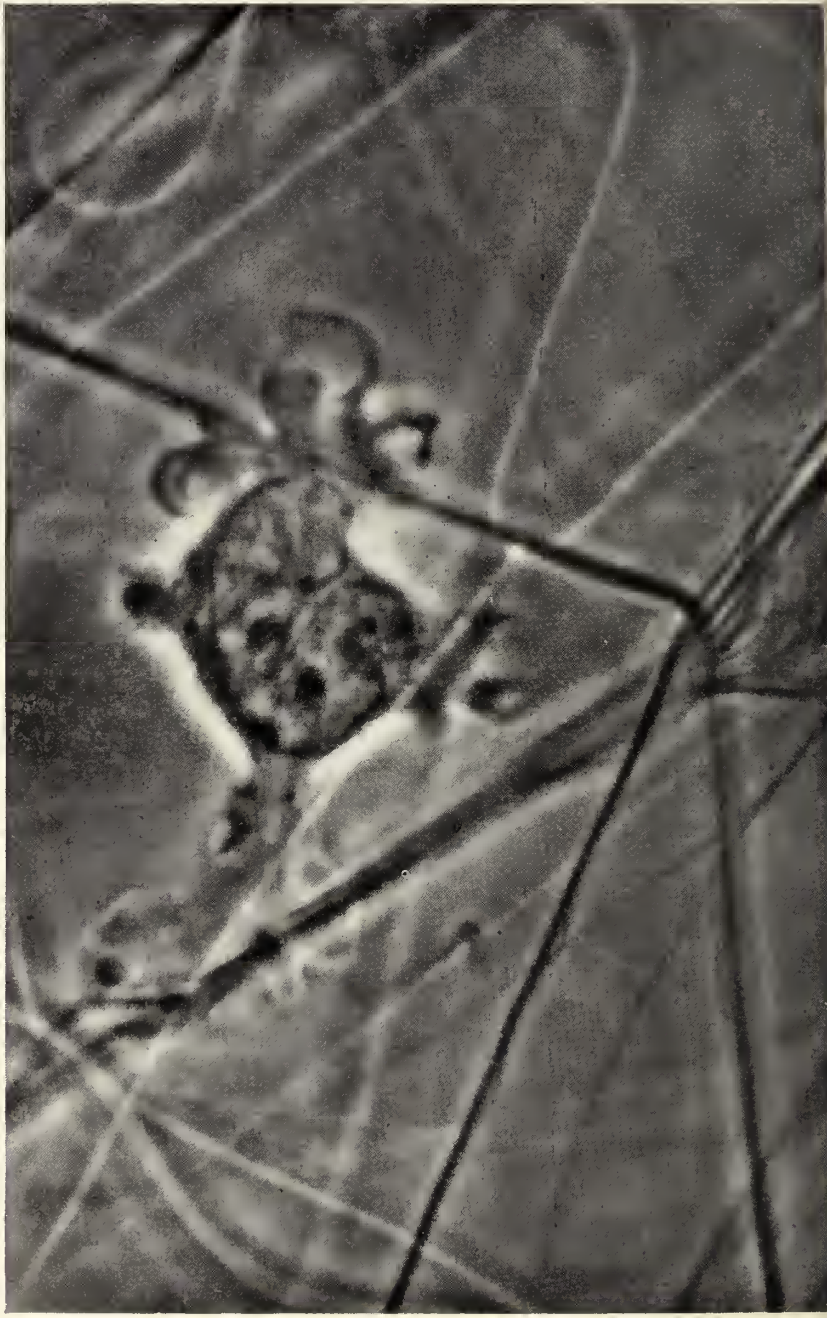
INFLAMMATION:

A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

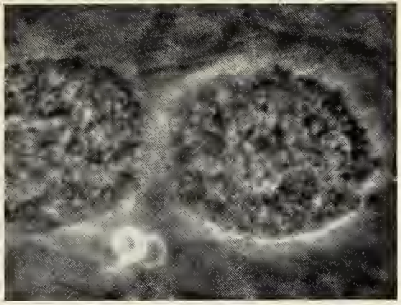


Visual evidence of how corticosteroids influence the inflammatory reaction

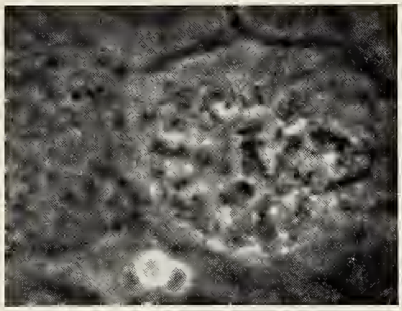
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



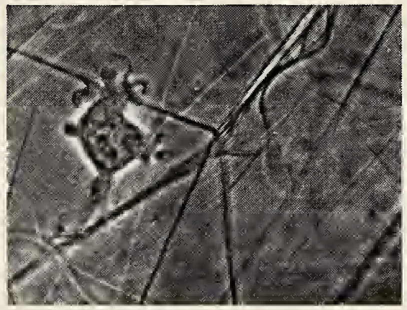
Phase-contrast microscopy showing mast cell before injury.



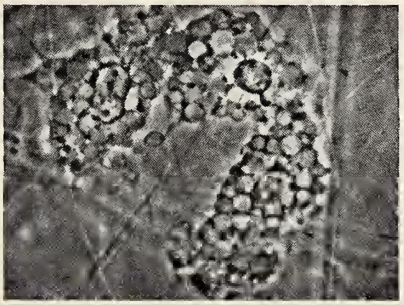
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

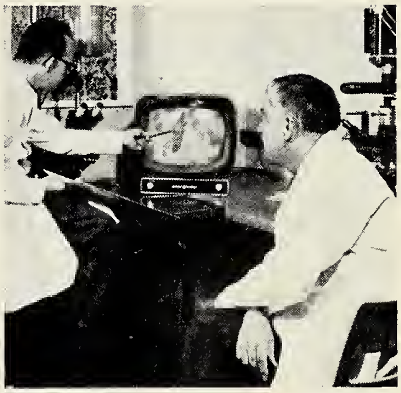
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



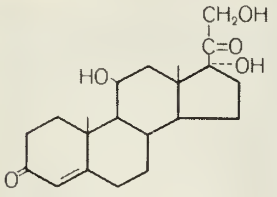
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

A New View of Corticosteroid Action in Inflammatory Dermatoses, a film based on this study, is now available from your Syntex representative.

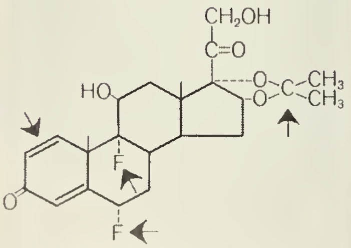
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone



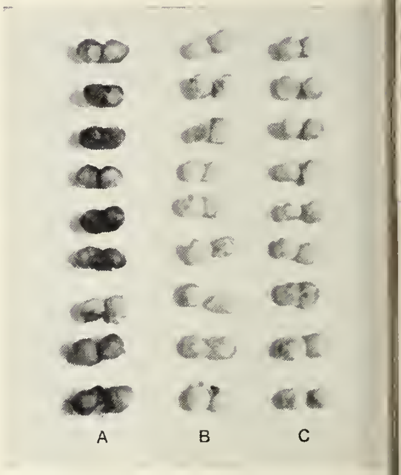
Fluocinolone Acetonide (Synalar)

- ☐ *a double bond between carbons 1 and 2*
- ☐ *fluorine substitutions at both the 6-α. and the 9-α positions*
- ☐ *the addition of the acetonide at the 16-α. 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.

THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes. CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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a topical corticosteroid
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(fluocinolone acetonide)

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one of the most active topical
corticosteroids available

Rapid and predictable
in antiinflammatory and
antipruritic activity

Results often comparable to
those of systemic corticosteroids
with fewer hazards

BELOW in the article is a list of 122 Michigan communities seeking family physicians. AT RIGHT is a chart of 53 Michigan communities now registered for 129 specialists. Physicians seeking to locate in Michigan communities and communities actively looking for physicians are served through the MD Placement Service of the Michigan Health Council, 712 Abbott, East Lansing.

Many Michigan Communities Registered With MD Placement Service of MHC

As a service to the people of Michigan and the profession of medicine, the Michigan Health Council conducts the M.D. Placement Program under the guidance of the Michigan State Medical Society.

Inaugurated in 1953, with less than 25 Michigan communities seeking assistance, the program has expanded rapidly as the need for doctors of medicine has grown.

THE MICHIGAN HEALTH COUNCIL currently has 122 communities that are seeking general practitioners. These include:

UPPER PENINSULA: Calumet, Crystal Falls, Escanaba, Ewen, Hancock, Houghton, Iron Mountain, Ishpeming, Laurium, Marquette, Newberry, Rock, Sault Ste. Marie and Stephenson.

NORTH CENTRAL: Alpena, Atlanta, Boyne City, Cheboygan, Hillman, Lincoln, Mackinaw City, McBain, Onaway, Posen, Rogers City and Vanderbilt.

WEST CENTRAL: Alma, Baldwin, Barryton, Bear Lake, Big Rapids, Breckenridge, Carson City, Cedar Springs, Cutlerville, Edmore, Evart, Fruitport, Grand Haven, Greenville, Hesperia, Holton, Howard City, Kent City, Lakeview, LeRoy, Manistee, Muskegon, Newaygo, Ovid, Portland, Ravenna, St. Johns, Shelby, Whitehall and Zeeland.

EAST CENTRAL: Auburn, Bad Axe, Bay City, Byron, Caseville, Cass City, Coleman, Columbiaville-Otter Lake, Elkton, Emmett, Flint, Goodrich, Hale, Lapeer, Lexington, Memphis, Metamora, Millington, Morrice, Mt. Pleasant, St. Clair and Sandusky.

SOUTHWEST: Addison, Albion, Allegan, Bangor, Baroda, Battle Creek, Benton Harbor, Buchanan, Burr Oak, Coldwater, Coloma, Decatur, East Lansing, Fennville, Grand Ledge, Hastings, Hillsdale, Holt, Jackson, Jonesville, Kalamazoo, Lansing, Litchfield, Marshall, Mason, Paw Paw, Plainwell, Potterville, Quincy, St. Joseph, Sturgis, Tecumseh-Adrian and Waldron.

SOUTHEAST: Ann Arbor, Detroit, Grosse Pointe Woods, Milford, New Haven, Romeo, Royal Oak, Saline, Sumpter Township, Troy and Whitmore Lake.

MEDICAL SPECIALISTS also are in great demand in Michigan. Fifty-three Michigan communities now are registered for 129 specialists with the Michigan Health Council's Placement Service. Some communities need only one additional specialist. Other communities are seeking several physicians in the same specialty and/or a wide number of medical specialties.

MHC is working with 30 communities that are seeking internal medicine specialists, 9 that are seeking general surgeons, 13 that are seeking psychiatrists and/or neurologists and 16 that are seeking pediatricians.

For more information concerning the openings, write or phone the Michigan Health Council; John A. Doherty, Executive Director; P.O. Box 431, East Lansing, Michigan 48823; Phone: (517) 337-1615.

	Anesthesiology	Dermatology	Ear-Nose-Throat	Industrial Medicine	Internal Medicine	Ob-Gyn	Ophthalmology	Orthopedics-Orthopedic Surgery	Otolaryngology	Otorhinolaryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology	Radiology	Research	Surgery	Urology	Rheumatology
UPPER PENINSULA																			
Calumet				X															
Crystal Falls					X														
Escanaba							X	X		X								X	
Hancock-Houghton			X		X			X				X						X	
Iron Mountain																	X		
Ishpeming-Negaunee					X			X				X							
Marquette		X	X											X					
Newberry														X					
Sault Ste. Marie			X		X	X	X					X							
NORTH CENTRAL																			
Alpena					X			X				X					X		
Charlevoix					X												X		
Lake City													X						
Traverse City													X						
WEST CENTRAL																			
Alma	X					X													
Grand Haven					X		X	X	X					X				X	
Grand Rapids									X										X
Greenville					X	X											X		
Ionia														X					
Manistee					X		X	X				X						X	
Muskegon													X						
Newaygo																	X		
St. Johns					X														
EAST CENTRAL																			
Flint					X								X						
Lapeer					X							X							
Mt. Pleasant			X		X	X						X	X	X			X		
Owosso						X						X						X	
St. Clair					X												X		
SOUTHWEST																			
Albion					X		X												
Allegan													X						
Battle Creek					X									X					
Benton Harbor										X		X							
Buchanan												X							
Coldwater					X		X						X						
Fennville					X	X						X					X		
Hastings					X														
Hillsdale					X		X											X	
Jackson			X		X		X		X			X		X					
Kalamazoo					X														
Lansing														X					
Marshall					X							X							
Niles					X			X											
Paw Paw					X							X					X		
St. Joseph					X				X			X		X					
SOUTHEAST																			
Birmingham														X					
Dearborn				X															
Detroit				X	X	X							X	X					
Howell					X														
Livonia						X													
Madison Heights			X				X		X			X							
Northville														X					
Pontiac													X	X					
Royal Oak					X														
Wayne					X														
MISCELLANEOUS																			
State-Wide Listings				X							X					X			
TOTALS	1	1	6	4	30	8	9	7	5	2	1	16	9	13	0	1	9	6	1

Facts re Suburbia:

How many Michigan physicians live or practice in the suburbs?

MSMS has no accurate figures, but the many suburban communities continue to prosper in the state.

The shortages of statistics and research have led to some false notions about suburbia in general.

The book *This U.S.A.*, published by Doubleday, reports that across the nation "there are a number of areas where the popular notion does not conform closely to the facts."

Quoting again from *This U.S.A.*:

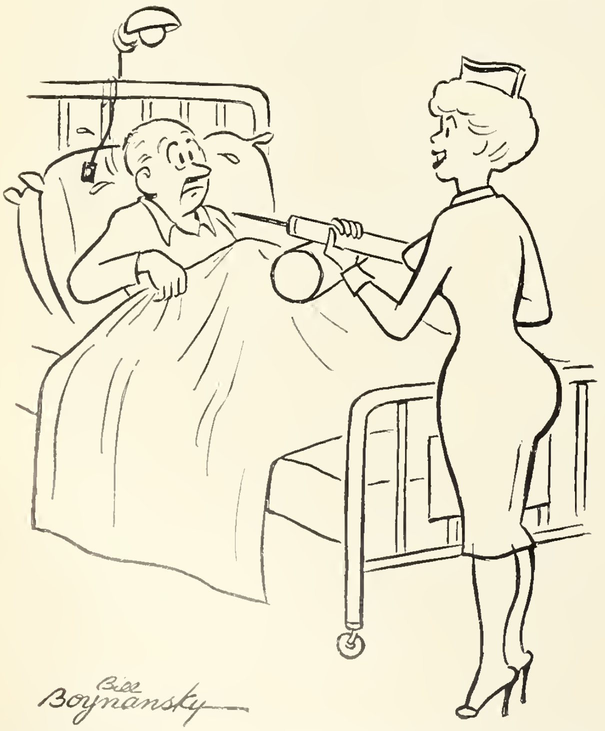
"The Notion: Suburbia is America's breeding ground.

"The Fact: The suburban fertility rate is only fractionally higher than that of the central city (suburb 1985; city 1956). The highest fertility rate is found on the farm (2377).

* * *

"The Notion: Suburbanites are always moving. They come from someplace else, soon they'll be going someplace else.

"The Fact: Although as noted previously, suburbanites do make inter-county moves somewhat more often, they do not move more often from house to house (suburban rate cumulative for five years from 1955-1960: 50% moved, versus city rate of 48%. Furthermore, suburbanites are not much more likely to be from out of state (suburban rate: 33% versus central city rate of 29%). Typically, then, suburban mobility is different only in the original move from the city to the suburb, which is often in the same state, but across county lines."



"Calm down, Mr. Bodkins, this is for spraying flies!"

* * *

Following are some other statistics from *This U.S.A.* from the U. S. Census:

"Suburbanites are richer. Family median income in the urban fringe: $7114; in the city: $5945; on the farm: $3228. More families earn $10,000 or more in the suburbs (24%) than in the city (17%). There are fewer families with incomes under $3000 in the suburb (10%) than in the city (18%).

"There are more families with children in the suburbs. In the fringe: 62%; in the city: 52%; on the farm: 55%.

"Suburbanites stay in school longer. Median number of school years completed for persons over twenty-five: suburbs, 12.0; city, 10.7; farm 8.8.

"Suburbanites are more likely to be employed. Unemployment rates: fringe, 4.6%; city, 5.5%; farm, 4.8% (in 1960).

"More suburbanites are employed as professionals, managers, and in white-collar work generally. White-collar rates: fringe, 50%; city, 45%.

"Suburbanites live in newer dwellings: 70% of the city dwellings were built prior to 1940, only 42% of the suburban dwellings are that old.

"Suburban homeowners are younger than city homeowners: 47% in the suburbs are between twenty-five and forty-four; in the city only 34% are between twenty-five and forty-four."

OEO FINANCES CENTER FOR BALDWIN AREA

A comprehensive neighborhood health services program for a low-income rural population in Lake County will become operational this fall under a $942,713 grant from the Federal Office of Economic Opportunity. It will be a joint effort of Michigan State University's College of Human Medicine, and Five-Cap, Inc., the local community action agency of OEO, and the Michigan Department of Public Health.

The demonstration program will affect all of Lake County and portions of Newaygo, Mason, and Manistee Counties. Many of the 9,000 residents in the four-county area live in poverty.

A neighborhood health services center in Baldwin will serve as the focal point.

Night Leg Cramps . . . Unwelcome Bedfellow In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]

now . . . specific therapy for night leg cramps

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Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchanism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

When the agitated geriatric disrupts the home...

His teen-age granddaughter won't invite friends home because of his outbursts.

for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ

His slovenly room and habits create more tension.

His disturbances at the table make every meal a nightmare.

His daughter can't please him. There is "just no living with him."

See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe . . . consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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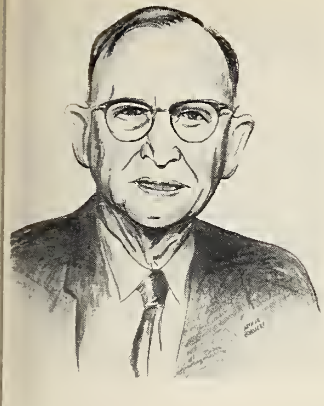


"If I have contributed anything, it is because I wanted to give to the schools and to the city of Flint what little service I was able."

Another Honor for Henry Cook, M.D.

"Physician of the Year" Served Flint Schools Well; Was MSMS President in 1937-38

BY ALICE SNELGROVE
OF THE MSMS STAFF

It is to Henry Cook, M.D., of Flint, a man of humble origin who has made great contributions to his profession and to society that the Michigan State Medical Society presents its highest award. Doctor Cook has been chosen "Michigan's Outstanding Physician of the Year."

Doctor Cook is the third physician to be so honored. He was preceded by Franklin L. Troost, M.D., Holt, and William A. Hyland, M.D., Grand Rapids, posthumously, in 1965 and 1966 respectively.

WITH HIS LONG record to dedicated public service Doctor Cook amply fills the awards criterion "That consideration be given to the physician's civic accomplishments as well as his professional accomplishments."

Perhaps his greatest single civic contribution has been in the field of education. For almost 36 years, over a third of a century, Doctor Cook served on the Flint Board of Education, and four separate times he was president of the Board. During his tenure Northern High School was conceived and built, and in recognition of his many contributions to Northern High, not only in planning and supervising its construction, but in rendering many years of invaluable service as team physician and unofficial coach, the new school auditorium was named Cook Auditorium in his honor.

The recent appointment of Doctor Cook to the Citizen's Advisory Committee of the Board of Education is an open acknowledgment of the fact that his opinions are still highly regarded.

DOCTOR COOK'S contributions to the Michigan State Medical Society and to the profession of medicine are no less meritorious. They began when he joined the Society in 1909 following his graduation from medical school. In 1936 he was chosen MSMS president-elect, and his year of

"I feel very humble as an individual. Never before did I recognize how much a man needs the help of his friends."

"Medicine is changing, has changed, and always should change — for the better, but we must never forget that we are dealing with sick people, who want exactly what we would want! A doctor should first know his business, be honest, and then practice the Golden Rule."

> **"As a profession, we should always fight for principle. A man without principle does not amount to much — always stand up and be counted."**
>
> **"If one fights fairly, he will make friends — and not enemies."**

service as president in 1937-38 was noteworthy for its expansion of committee responsibilities and his strict insistence that each physician do his very best to improve medical care in his own community.

In addition to his year as president, Doctor Cook was a member of The Council for 12 years preceding his presidency.

DURING HIS TENURE on The Council, Blue Cross-Blue Shield was born. By his own statement, he was a delegate to the MSMS House so many times that he lost count. In 1959 he was given a 50-Year Pin for his half-century of service.

He was voted president-elect of the Genesee County Medical Society in 1946, but he resigned his position in favor of Walter Rundles, Sr., M.D., who had been elected previously, but owing to his service in World War II had been unable to fulfill his term. In acknowledgment of Doctor Cook's services, the Genesee County Medical Society elected him president-for-a-day on January 7, 1960.

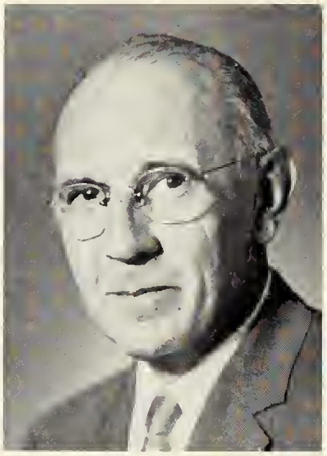
Included among his many professional memberships are the American Industrial Medical Association and the Michigan Industrial Physicians Association, the latter of which he served as president. He was the surgeon for the Grand Trunk Railroad for many years and was examiner and consultant for the Flint Board of Education and the Flint Trolley Coach Company.

For the record, Doctor Cook has continued his practice in the Flint area since his graduation from Detroit College of Medicine and Surgery (now Wayne State University Medical School) since 1909. That time represents a total of 58 years, interrupted only once, during his service in the AEF Medical Corp during World War I.

Doctor Cook served as chief of staff at Hurley Hospital for nine years, from 1939 to 1948. During that period the 750-bed institution had a great period of expansion and growth. He is well remembered for his fine contributions to the Hospital.

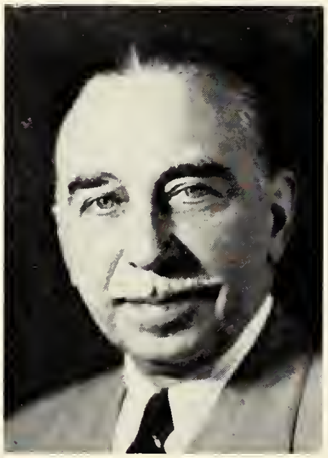
Doctor Cook's interests are not confined simply to education and the medical profession. Although these have been the two dominant interests of his life, he has many absorbing hobbies and an enduring interest in his family.

AMONG HIS HOBBIES are gardening and hunting, and he once was crowned city bridge champion. For many years he has been a member of the Elks, Masons, and Knights Templar. As for his family, he is the father of four sons, two of whom are surgeons now practicing in Flint. Another son is in the insurance business, and the fourth is in pharmaceutical retailing.



F. L. TROOST, M.D.,
OF HOLT,

1965 RECIPIENT



WM. A. HYLAND, M.D.,
OF GRAND RAPIDS,

1966 RECIPIENT,
POSTHUMOUSLY

DORSEY "FLU-GRAM"

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timed-release tablet contains:

Triaminic® .... 50 mg.
(phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)
Dextromethorphan hydrobromide .... 30 mg.
Terpin hydrate .... 180 mg.
Acetaminophen .... 325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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a division of The Wander Company
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Tussagesic timed-release tablets

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Representative

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*PENTOBARBITAL (ACID)............ 1/8 GR.
*Warning: may be habit-forming

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

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SYNIRIN is another pharmaceutical achievement

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Manufacturers of ethical pharmaceuticals since 1856

viewpoints

Family Life Challenge

BY WINSLOW G. FOX, M.D., CHAIRMAN
MSMS COMMITTEE ON MEDICINE
AND RELIGION

Family Life Education is finally getting more attention.

Many of us see patients every day who could have derived a lot of benefit from knowing what they were getting into, in marriage. Some are immature teen-agers, swept into marriage by a romantic frenzy, without any concept of the long pull of steady responsibility, and putting others first, that a happy and successful life together demands.

Some are immature gray-haired oldsters, whose selfishness has never been tutored into unselfishness. Their shortcomings become painfully obvious when they are unable to put the needs of their children, or the needs of their spouse, above their own needs, without pouting and becoming bitter.

WE AS PHYSICIANS are called upon to play a larger role in this Family Life Education movement. The Public Forum, September 28, of the Michigan State Medical Society Annual Session was devoted to this area of concern.

We must not let ourselves be so preoccupied with "sick people" that we do not devote time and energy to these less tangible, and preventative aspects of medical practice.

Where do we "fit-in," or what role should we play?

To answer these questions, many physicians have found that they can converse on a high plane of intelligence with their local minister. Whether that clergyman be called a pastor, rabbi, or priest is not so important – since each of them seems to share an educated concern in this area.

THE MSMS COMMITTEE on Medicine and Religion has long sought to bring doctors and ministers together, for meaningful dialogue. Not only have many new friendships risen from such activity, but many physicians have found, perhaps for the first time, that their local clergyman is a person professionally competent to deal with many human problems.

In this particular area of Family Life Education, there is "built-in" basis for dialogue between doctors and ministers. Each brings his particular concern and insight. An educational movement, such as this, requires the disciplines and inspirations of both physicians and clergy.

Many County Societies have active Medicine and Religion Committees. Others may have been waiting for some stimulus to initiate activity in this area.

There is enough challenge in the field of Family Life Education to call for the best talents in both medicine and religion, to work together for the enrichment and uplifting of life.

More Auxiliary Members Are Needed in Michigan

BY W. G. GAMBLE, JR., M.D., EDITOR
BAY-ARENAC-IOSCO COUNTY
MEDICAL SOCIETY BULLETIN

Approximately one half of the wives of the physicians in Michigan do not belong to the Medical Auxiliary.

This means that there is a vast amount of woman-power which has not been channeled into the local, state, or national auxiliaries. In other words, while MSMS members comprise approximately 7,000 plus doctors, only 3,400 of their wives belong to the Medical Auxiliary.

IT IS TRUE that some of these wives are tied down by household duties and children, others by reason of special abilities in the arts and sciences and the pursuit of higher education, have little or no time for outside social duties. This is especially true of smaller counties where they work with hospital auxiliaries, in which they are doing an excellent job.

The word "Auxiliary" comes from a Latin word "Auxiliarius" meaning conferring of help or aid, serving to supplement individuals whom they are associated with. Someone has well said "Never underestimate the power of a woman."

IN VIEW OF the crises facing the medical profession today in the various fields mentioned, this powerful reservoir of feminine gender might take off some of the pressure from their husbands and might also enable them to live longer and enjoy their society. Certainly, in the socio-economic and legislative field, this 50 percent could be of immense value. They have direct contacts not only in the country club set but in teas, bridge clubs, bowling clubs, and other feminine associations. Other groups, too, can be informed of the goals, achievements, and problems facing the health care today.

Of course, the Michigan State Medical Society could inform the ladies directly (this is no reflection on the excellent job the executive staff is doing). It's a fair wager that much of the excellent material sent out could be intelligently read, interpreted, and acted on if sent to members of the Medical Society Auxiliary.

Setting up a separate department at our MSMS headquarters at this time is not the suggestion, but much of the material *is* lost or forgotten in the average physician's office, and while he makes excellent resolutions, the material is finally filed in W.B. file.

ONE REALIZES that the prime object of the doctor is to practice medicine, but he will have to reorient himself that today is a new day and each day brings new challenges. To quote: "A physician sometimes heals, often relieves, but always consoles."

This, is not an implication that a woman should neglect her home, husband, or children, but with all the new labor-saving devices, she has sufficient time to enter matters outside her home. Today woman is equal partner to man and should walk beside him. In fact, it is believed sometimes many of them walk ahead of him.

Wives of Doctors, woman-power is needed.

Join and work in your medical auxiliary.

Not the Only Ones . . .

(Editor's Note: The following is excerpted from a speech by AMA President Milford O. Rouse, M.D., at the recent AMA Communications Institute.)

"As physicians, we need to seek out the leaders of other fields in the community so we can pool our considerable resources to attack problems in concert rather than individually.

"We physicians are not the only ones worried about preserving our traditional system of health care . . . while, at the same time, expanding its effectiveness and increasing its availability to all the people of the community.

"We physicians are not the only ones concerned about government encroachment into virtually every private section of our society and economy.

"We physicians are not the only ones determined to see private enterprise strengthened and who want to see the community solve its own problems rather than turning for solutions to the state or federal government.

"We consider these problems and look for solutions, too often, only among our own members, without soliciting and gaining the tremendous help that is available to us from the other segments of the community, whose leaders are just as eager as we to preserve, expand and strengthen the traditions of freedom and personal responsibility.

when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka

Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avo
those responsive to routine measures as well as contraindicate
tients. Obtain a detailed history and a complete physical and labo
examination, including a blood count. The patient should not e
recommended dosage, should be closely supervised and shou
warned to discontinue the drug and report immediately if fever,
throat, or mouth lesions (symptoms of blood dyscrasia); sudden w
gain (water retention); skin reactions; black or tarry stools or
evidence of intestinal hemorrhage occur. Make regular blood co
Discontinue the drug immediately and institute countermeasures
white count changes significantly, granulocytes decrease, or imm
forms appear. Use greater care in the elderly and in hyperten

Adverse Reactions: The most common are nausea, edema and
rash. Swelling of the ankles or face may be minimized by withho
dietary salt, reduction in dosage or use of diuretics. In elderly pa
and in those with hypertension the drug should be discontinued
the appearance of edema. The drug has been associated with pep

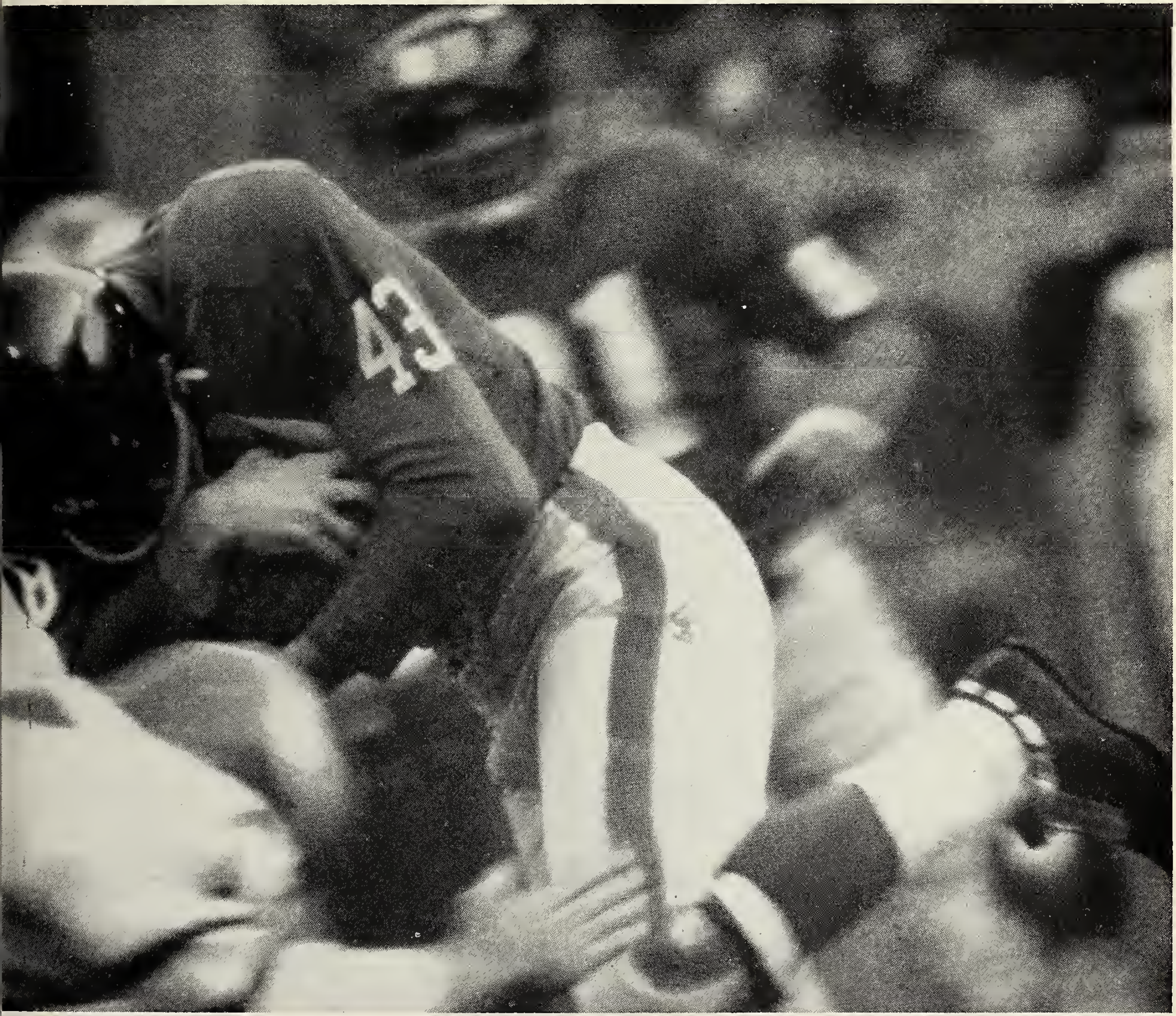
280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the
nizing pain of shoulder bursitis.

iot for every patient. Check carefully the Contraindications, Warning and
:autions shown below.

adverse reactions may occur. The most common are nausea, edema and rash.
ely, agranulocytosis has been reported. All adverse reactions are listed below, too.

-for-pay or workaday patients—when they come up with shoulder bursitis and your
ical judgment indicates Butazolidin alka—go with it.

watch the comeback.



d may reactivate a latent peptic ulcer. The patient should be in-
d to take doses immediately before or aftor meals or with
minimize gastric upset. Mild drug rashes frequently subside
eduction of dosage. However, rash accompanied by fever or
systemic reactions usually requires withholding medication.
ic rash has also been reported. Agranulocytosis, exfoliative
itis, Stevens-Johnson syndrome, or a generalized allergic re-
similar to serum sickness may occur and require permanent
awal of medication. Stomatitis, salivary gland enlargement,
ig, vertigo and languor may occur. Leukemia and leukemoid
ns have been reported. While not definitely attributable to the
a causal relationship cannot be excluded. Thrombocytopenic
a and aplastic anemia may occur. Confusional states, agitation,
che, blurred vision, optic neuritis and transient hearing loss have
eported, as have hyperglycemia, hepatitis, jaundice, and several
of anuria and hematuria. With long-term use, reversible thyroid
lasia may occur infrequently. Moderate lowering of the red cell
due to hemodilution may occur. 6509-V(B)R2

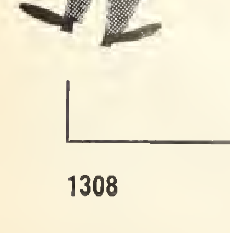
Butazolidin® alka
Capsules

100 mg.	phenylbutazone
100 mg.	dried aluminum hydroxide gel
150 mg.	magnesium trisilicate
1.25 mg.	homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, New York



about doctors and their friends

James T. Howell, m.d., executive director of Ford hospital in Detroit, was elected to a three year term on the board of trustees of the American Hospital Association at its recent meeting in Chicago. Emory W. Morris, president of the W. K. Kellogg Foundation in Battle Creek, received an award of honor from the association.

Robert L. Loftin, m.d., has recently succeeded V. K. Volk, m.d., as Director of the Health Department of Saginaw County. He comes to the Saginaw position from private practice in Broken Bow, Oklahoma. He is also former head of the combined Bay City-County Health Department.

John C. Wells, Jr., m.d., a retired Air Force colonel, is the new director for the Muskegon County Health Department. He replaces George P. Sweda, m.d., who is with the Health Department in Detroit.

George Moriarty, m.d., has been appointed as new chief physician of the Detroit Police Department, replacing Wilford S. Wood, m.d., who has retired after 30 years service. Also appointed to the medical staff are Melvin L. Hollowell, m.d., first Negro to join the staff, and Conrad F. Bernys, m.d.

Jacob J. Miller, m.d., medical director of Our Lady of Providence School at Plymouth, and Lyle M. Allis, m.d., who formerly practiced at Niles, have been added to the active staff of Mercywood Hospital, Ann Arbor.

A. H. Keefer, m.d., Concord, who has served a three-county area for more than 30 years was recently honored with a reception at Concord High School. A highlight of the event was the presentation to Doctor and Mrs. Keefer of a check to be used for a vacation.

Girard Veenschoten, m.d., is the new medical director of District Health Department No. 1. Formerly with the Allegan County Health Department, Doctor Veenschoten began his duties upon the completion of graduate work at the University of Michigan School of Public Health. District Health Department No. 1 serves Missaukee, Wexford, Kalkaska, and Crawford counties.

John H. Carter, m.d., Benton Harbor, has been named chairman of the professional division of the United Community Fund.

Captain Duane John Glatz, m.d., former Lansing resident, was decorated with a Bronze Star for heroism and an Air Medal for meritorious achievement for his service as a flight surgeon in Vietnam. Captain Glatz received an M.D. degree from the University of Michigan in 1964.

Edward R. Weddon, m.d., Stockbridge, has been reelected secretary of the Stockbridge Board of Education. Doctor Weddon also will serve as chairman of the committee on purchasing.

Chairman of the section on "Cancer of the Gastro-Intestinal Tract" at the 1968 National Cancer Conference, September 1968, will be H. Marvin Pollard, m.d. The three-day Conference will be held at the Denver-Hilton Hotel in Colorado.

"Current Trends in Medical Education" were discussed at the Washtenaw County Medical Society's September meeting by William N. Hubbard, Jr., m.d., U-M Medical School dean.

Many Wayne County Medical Society members enjoyed a great day of golf and fellowship, at the annual Golf Tournament at Hillcrest Country Club.

Many newspapers across the state carried a feature story recently about Sherman Loupee, m.d., Dowagiac, when he observed his 95th birthday. Doctor Loupee was honored at the MSMS Centennial in Detroit as the only living Michigan doctor who had ever served in the Michigan Legislature. He held a seat for four terms, beginning in 1938. MSMS in 1952 named him the "Michigan Doctor of the Year." Two months ago, Doctor Loupee underwent surgery and has been convalescing. He has kept his office open and hopes to return to practice. His son, George Loupee, m.d., also practices in Dowagiac.

DOCTOR,

Here is the expanded Abbott anorectic program designed to meet the individual needs of your overweight patients.

ABBOTT

THE PRODUCT

DESOXYN® Gradumet®
METHAMPHETAMINE HYDROCHLORIDE IN LONG-RELEASE DOSE FORM

5 mg. 10 mg. 15 mg.

DESBUTAL® 10 Gradumet
10 mg. METHAMPHETAMINE HYDROCHLORIDE, 60 mg. SODIUM PENTOBARBITAL

FRONT SIDE

DESBUTAL 15 Gradumet
15 mg. METHAMPHETAMINE HYDROCHLORIDE, 90 mg. SODIUM PENTOBARBITAL

FRONT SIDE

MOOD ELEVATION

DESOXYN Gradumet

Smooth appetite control plus mood elevation

Typically, the obese patient is a repeat dieter. And with each failure, the task looks more hopeless. Therefore, it is often just as important to lift the mood as to curb the appetite. Desoxyn Gradumet does just that. It gently elevates and sustains the mood. And no other product—amphetamine or non-amphetamine—is more effective in suppressing appetite.

DESBUTAL Gradumet

For patients who can't take plain amphetamine

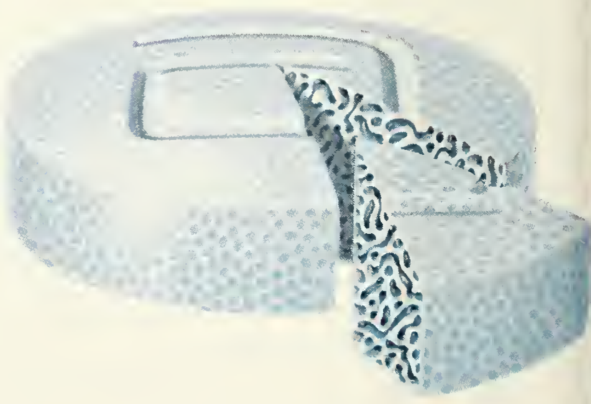
Desbutal Gradumet contains 2 drugs, each in its own tablet section, combined back to back to form a single tablet. One section contains Desoxyn to suppress the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to soothe the patient and counteract any excessive stimulation. The drugs are released in an effective dosage ratio throughout the day.

CONTROLLED-RELEASE

HOW IT DIFFERS FROM LONG-RELEASE

The Gradumet is made up of thousands of interconnecting channels, much like a sponge. These channels—filled with a drug—end at the outer surface of the tablet. When fluid comes in contact with the Gradumet, the drug in the outer ends of the channels dissolves. As the fluid makes its way up the channels, there is a continuous release of medication.

Since the rate of release is rigidly determined by the size and number of channels, the Gradumet is able to provide controlled-release as well as long-release. Patients get a measured amount of medication, moment by moment, throughout the day—from a single oral dose.



THIS IS A RELEASE YOU CAN COUNT ON

THE PROGRAM

WEIGHT CONTROL BOOKLET

To help your obese patients understand why they are overweight—and what they can do about it—Abbott has a booklet called "The Secret of Controlling Your Weight." *It is available to your patients only through you.*

Here is a partial list of the topics covered:

Why you are overweight
Rewards of weight reducing
Balanced meals
Helpful hints
Hunger between meals
Snacks
Weekly weighings
Exercise
Holidays, vacations, special events
Leanness and longevity

Each topic is covered on one page in simple and easy-to-understand language. At the back of the booklet, there is a list of 160 foods showing their caloric content.

the
secret
of
controlling
your weight

FOOD DIARY

The Food Diary is designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing everything down that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

This booklet also lists the caloric content of 160 foods.

See Brief Summary on next page.

THE PRICE

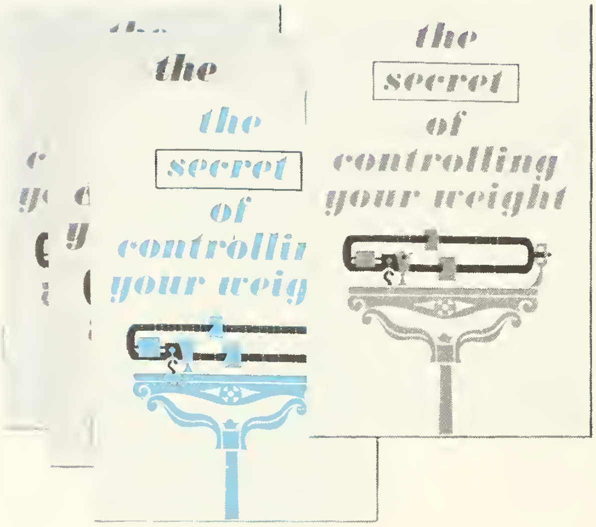
ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Desoxyn Gradumet and Desbutal Gradumet are so reasonably priced that patients in many cases save enough (compared to other leading long-release anoretics) to get five weeks of medication for the price of four.

FREE SUPPLIES



There are four weight control booklets, each with the same text, but with a different sample in the back of the booklet to meet your individual patient's needs. You have your choice of Desoxyn Gradumet in 10 mg. or 15 mg. strengths as well as Desbutal 10 Gradumet and Desbutal 15 Gradumet. The Food Diary is the same for all of the weight control booklets.

Your Abbott man will be happy to supply you with booklets. Just ask him.

CONTRAINDICATIONS: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

PRECAUTIONS, SIDE EFFECTS: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and addiction.

Amphetamine side effects such as a headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is usually transient.

701069

ABBOTT

Gradumet—Long-release dose form, Abbott: U.S. Pat. No. 2,987,445.

MSMS Judicial Commission Nominees Named

MSMS Judicial Commissioners for Districts 1, 5, and 7 will soon be elected. At present six men have been nominated by the Judicial Commission Nominating Committee. They are:

District 1 — C. Jackson France, M.D., Detroit; Robert H. Hamburg, M.D., Detroit.

District 5 — Sherman E. Andrews, M.D., Kalamazoo (incumbent); Harold J. Meier, M.D., Coldwater.

District 7 — Reader J. Hubbell, M.D., Traverse City (incumbent); W. H. Huron, M.D., Iron Mountain.

Any additional nominations can be made by a petition bearing the signature of not less than 25 voting members of the Michigan State Medical Society. Nominations must be sent to the MSMS Secretary, Kenneth Johnson, M.D., 120 West Saginaw Street, East Lansing, Michigan, before October 15.

Judicial Commissioners serve for terms of three years.

Ballots will go out before November 10 and will be returned by December 1.

MHC-MMS Career Folder Seeks 50,000 for "Team"

"We need you and 50,000 more by 1970."

So declares a new, handsome flier given to every student visiting the Michigan Health Careers Mobile.

The flier uses photos of people working in the medical fields and describes all the exhibits in the Careers Mobile.

One of the outstanding features of the flier is a postal card which permits the student to ask the Michigan Health Council for information about the health-team members.

The fliers were financed by the Health Council, in cooperation with Michigan Blue Shield.

Notices About VA Home Town CHAMPUS Fees

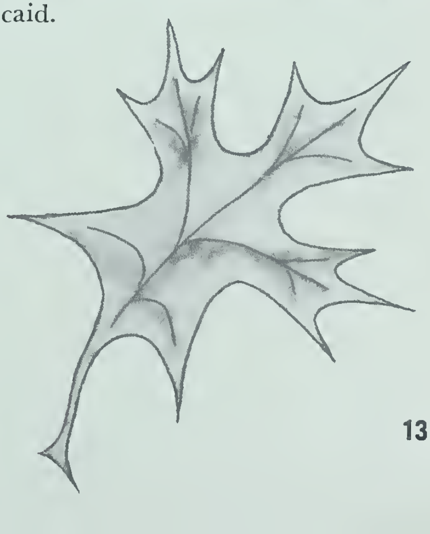
V.A. HOME TOWN CARE PROGRAM

Similarly, the Committee on Governmental Medical Care Programs was in negotiation with the Veterans Administration seeking the same payment formula as the Medicare and Medicaid programs. Because this matter could not be resolved to the satisfaction of MSMS, the Veterans Administration has advised that no contract will exist with MSMS during the coming year on a trial basis. The V.A. also advises that "our rates will be generally consistent with the usual and customary fees," and "in the absence of a negotiated fee schedule, maximum rates will be established by the Veterans Administration."

CHAMPUS

MSMS has received a directive from CHAMPUS, (Civilian Health and Medical Program of the Uniform Services), that, at the expiration of the contract between MSMS and CHAMPUS on October 31, 1967, the "usual, customary and reasonable" fee concept should be followed.

Apparently influenced by the Medicare Program, the Department of Defense made this major change in its system of payment for the medical care of military dependents under this program. The MSMS Committee on Governmental Medical Care Programs had been in negotiation with representatives of the Department for a reimbursement concept of "usual, customary and reasonable" fee as is now being developed by the Michigan Medical Service (fiscal carrier) for both Medicare and Medicaid.



MARMP Office Opened; Elect Four to Board

The Michigan Association for Regional Medical Programs has opened its headquarters at 1111 Michigan in East Lansing.

Albert E. Heustis, M.D., state commissioner of health for many years until his recent resignation, began full time duties October 1 as the first executive director of MARMP. Several initial project proposals have been prepared by the MARMP central staff since the $1,285,155 planning grant from the National Institutes of Health became effective June 2, 1967.

The recent second annual meeting of MARMP re-elected William N. Hubbard, Jr., M.D., U-M Medical School dean, as president.

Don Marshall, M.D., MSMS Councilor from Kalamazoo, was returned as vice-president, and Andrew D. Hunt, Jr., M.D., dean of the MSU College of Human Medicine, was renamed secretary.

WSU Medical School Dean Ernest D. Gardner, M.D., was elected as treasurer.

The annual meeting selected four new members to the Board September 13. They were D. Eugene Sibery, executive director of the Greater Detroit Area Hospital Council; Ronald D. Yaw, administrator of Blodgett Memorial Hospital, Grand Rapids; Gus Scholle, Detroit, a representative of the public on the MARMP Regional Advisory Group, and Doctor Heustis.

A resolution of appreciation was adopted by the annual meeting thanking Mr. Sibery, for his service as program coordinator pro tem while MARMP looked for an executive.

WATCH NEWS EXTRA FOR ANNUAL SESSION ARTICLES, PHOTOS

The news extra issue of Michigan Medicine will carry photographs and news articles from the MSMS Annual House of Delegates and Scientific Session, September 24-29.

The only Annual Session news reported in this October issue is the story about the selection of Henry Cook, M.D., Flint, as "Michigan's Outstanding Physician of the Year."

Michigan Internists To Confer Oct. 27-28

Specialists in internal medicine in Michigan will hold a scientific meeting in Ann Arbor October 27-28 under the auspices of the American College of Physicians. The meeting will be at the University of Michigan.

Among special guests will be Rudolph H. Kampmeier, M.D., Nashville, Tenn., President of the American College of Physicians and Professor of Medicine Emeritus, Vanderbilt University School of Medicine.

Noyes L. Avery, Jr., M.D., Grand Rapids, Michigan, ACP Governor for Michigan, is in general charge of the meeting.

CHILDREN'S HEALTH CENTER DEDICATION SOON: GIFT OF MOTT

A new two and one-half million dollar addition to the C.S. Mott Foundation Children's Health Center in Flint will be dedicated on Sunday, October 22, at 2:00 PM in the Woughter Auditorium.

Following the dedication, there will be an open house for the public in the center. Members of the Genessee County Medical Society are invited to the dedication and open house.

The Center is located at 806 West Sixth Avenue.

Ouch! Physicians Alerted to Problem Of More Disposable

Every MSMS member is urg
to double his care in the handli
of disposable hypodermic needl
and other similar medical pro
ucts.

MSMS officials are keenly co
cerned about this possible proble
because of the larger number
disposables being offered for u
in physicians' offices.

A case recently was brought
the attention of MSMS where ch
dren had been able to secure d
carded hypodermic needles from
dumping area and were using the
in their play.

TRAUMA SYMPOSIUM PLANNED DEC. 6-7; LISTS 30 TOPICS

The 15th Annual Symposium o
Trauma, expanded this year to
two-day meeting in conjunctio
with the observance of Way
State University's Centennial yea
will be December 6 and 7 at t
Wayne County Medical Society i
Detroit.

Sponsors are the Michigan Con
mittee on Trauma of the Amer
can College of Surgeons. Wayn
State University School of Med
cine, and Parke Davis and Con
pany.

General chairman is Joseph
Posch, M.D., clinical associate pr
fessor of general surgery at Wayn
State University.

Some 30 subjects will be cover
at the meeting, including: Th
Team Approach in a Riot Are
Disaster Programs, Emergenc
Room Problems, Occupation
Hazards, and Athletic Injuries.

Last year's symposium drew 45
doctors from Michigan, Ohio, Ill
nois, Indiana and Ontario.

iscoe to Head ealth Planning ouncil in State

The Michigan Health Facilities ınning Council has a new chair- ın and a new name.

The new Chairman of the or- ıization is D. Bonta Hiscoe, D., of Lansing.

Its new name is the *Health ınning Council of Michigan.*

Doctor Hiscoe succeeds W. An- ı Hedgecock, Vice President of nsumers Power mpany, Jack- ı. Bylaws of Council were ıended to oaden its scope interest and ac- ity. Edwin S. rsh, Council rector, review- the organiza- nal activities of the five outstate ional member planning councils l ten metropolitan area bodies w working in cooperation with State Council. Voluntary Com- nity Councils are now orga- ed in Flint, Saginaw, Bay City, kson, Lansing, and Grand Rap-

HISCOE

RVEY FINDS MANY VOR FLUORIDATION

Seventy-one percent of those in- viewed agreed that fluoridation drinking water is a good idea.

That was one of the findings of ecent poll conducted by Market- Strategy, Inc., of Detroit, for Democratic State Central Com- ttee. The survey consisted of 00 interviews of a cross section adults throughout the state.

The poll, primarily on current ıes, asked the 1,000 for their itical affiliation and found that) were independents, 365 demo- ts and 225 republicans.

Busy Autumn For Legislative PR Activities

The September report of Executive Director Hugh W. Brenneman to The MSMS Council contained some progress reports of interest to the full membership:

"MSMS sponsored a News Dinner in Grand Rapids on September 14 and a News Luncheon in Detroit on September 20 to help promote the 1967 Annual Session and to explain the work of the MSMS International Health Committee. Speakers at each included MSMS President C. Allen Payne, M.D., and International Health Committeeman Alfred Swanson, M.D.

"The Health Careers Mobile, since its visit to Mackinac Island in July, continued its successful tour visiting the following: Macomb Mall at Mt. Clemens, Ingham County Fair at Mason, Ionia Free Fair, Michigan State Fair in Detroit, Midland County Fair, St. Louis Festival, and several schools in Flint before moving to Grand Rapids for the MSMS Annual Session.

"An increasingly high level of committee activity has been maintained by the Michigan State Legislature since its adjournment on August 3. MSMS witnesses have testified or MSMS statements have been submitted for the record on several questions (ambulance licensure, fluoridation, abortion, chiropractic liscensure) and informal discussions have been held with the State Executive Office on matters of governmental organization and comprehensive health planning.

"The special study group of the Legal Affairs Committee charged with analysis of a proposed "single medical practice act" has been proceeding with its study of HB 2707 as introduced during 1967, and related information developed by the State Board of Registration in Medicine."

Ophthalmologists Meet In Lansing, Nov. 16

The first meeting of the 1967-68 calendar for the Michigan Ophthalmological Society will feature Webb Chamberlain, M.D., Cleveland, at the Jack Tar Hotel, Lansing, November 16.

Doctor Chamberlain will discuss "Complications in Vertical Strabismus, with Robert J. McDonald, M.D., Royal Oak, as a co-discusser.

MSU STARTS 2nd CLASS

Michigan State University's College of Human Medicine has accepted its second medical class of 26, like the first.

The MSU program provides three years of instruction which prepares students for transfer at the junior level to medical schools offering the M.D. degree.

The State Board of Education has recommended to the governor and legislature that MSU proceed to a full medical degree-granting program, but no schedule has been set or funds appropriated for establishment of a full program.

Class size of the college of Human Medicine will be enlarged to 64 students when the proposed $9.6 million Life Sciences Building is built.

Eleanor Skufis, M.D., left, Adrian, discussing MSMS Family Life Education efforts with Lorene Babcock on the "Living Show" of WWJ-TV, Channel 4 in Detroit, on September 4.

U.S. Smoking-Health Report Tells Research Findings

Highlights of the recent second U.S. Public Health Service report on smoking and health are explained by the Michigan Council on Smoking and Health.

The Michigan Council (MSMS is a supporting member) is currently assisting the Michigan Congress of Parents and Teachers in a state-wide educational effort.

A second report summarizes three and one-half years of research and study into the health dangers of smoking. The Department of Health, Education and Welfare said the report confirms and strengthens the conclusions of a 1964 report. The second report provides new technical data on the relationship of smoking to cardiovascular, chronic bronchopulmonary disease, cancer and other conditions.

The research has found that:

—Cigarette smokers have substantially higher rates of death and disability than their nonsmoking counterparts in the population. This means that cigarette smokers tend to die at earlier ages and experience more days of disability than comparable nonsmokers.

—A substantial portion of earlier deaths and excess disability would not have occured if those affected had never smoked.

—If it were not for cigarette smoking, practically none of the earlier deaths from lung cancer would have occurred; nor a substantial portion of the earlier deaths from chronic bronchopulmonary diseases (commonly diagnosed as chronic bronchitis or pulmonary emphysema or both); nor a portion of the earlier deaths of cardiovascular origin. Excess disability from chronic pulmonary and cardiovascular diseases would also be less.

—Cessation or appreciable reduction of cigarette smoking could delay or avert a substantial portion of deaths which occur from lung cancer, a substantial portion of the earlier deaths and excess disability from chronic bronchopulmonary diseases, and a portion of the earlier deaths and excess disability of cardiovascular origin.

Seek Better School-Physician Communications

"At present, communication is erratic, haphazard, and often works against the best interests of the child," says John M. Dorsey, M.D., chairman of the Michigan State Medical Society's Child Care Committee, in discussing the communication gap between parent, physician, and teacher.

"Because the number of school physicians is declining, teachers often make medical diagnoses and physicians educational ones, because the child is in front of them," Doctor Dorsey continued.

"The parent is often in the middle," Doctor Dorsey said. "As the one who has final responsibility for the child, he is put in the difficult position of being the purveyor of both medical and educational information."

To establish better communication between parent, physician, and teacher, Doctor Dorsey, in consultation with the Oakland County Medical Society, Osteopathic Society, and the Board of Education, has developed a brief form for teacher and physician to be used in Oakland county schools this fall.

One side of the form will be filled out by the teacher. It calls for a description of the behavior and questions which the behavior has raised. The form then goes to the parent for release to the physician, if the parent agrees.

The physician, after examining the child, fills out the other side of the brief form, including a statement of medical history, present findings, and further recommendations. For the physician's convenience, the form is only one page long and will be finally kept not in his office, but in the school records.

After teacher and physician have made their respective educational and medical diagnoses, the parent is in a position to make an intelligent and informed decision to meet the child's problem in the best possible way.

"With education and medicine becoming increasingly sophisticated, we hope through these forms," Doctor Dorsey concluded, "to help solve the problem of communication."

Donnagel®
For treatment of Diarrhea
Each fluid ounce contains:
SHAKE WELL
4 fl. oz.
A·H·ROBINS

"Man's best friend" in wintertime diarrheas

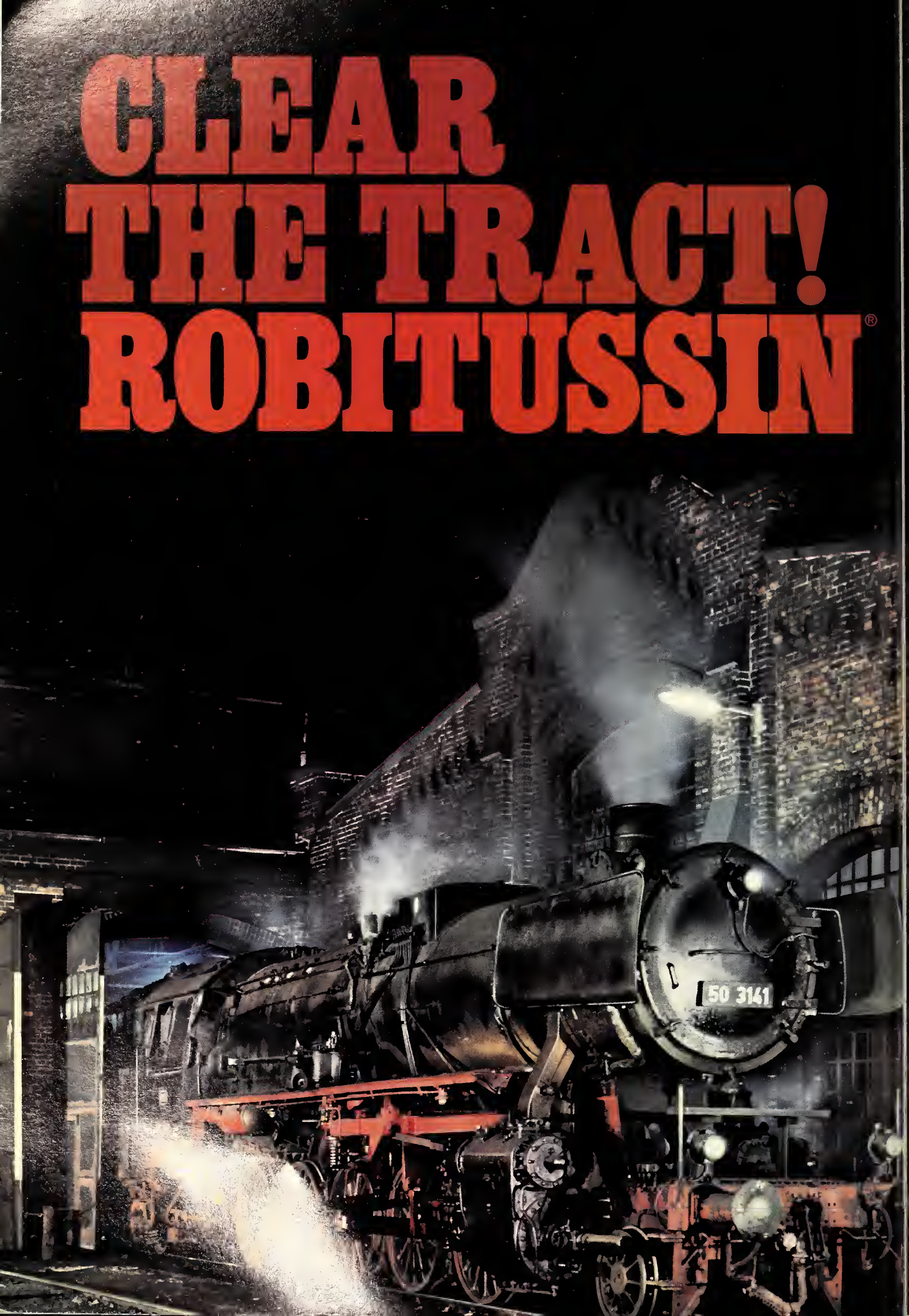
ı winter "flu" and viral astroenteritis, Donnagel (4 oz. ize!) can bring aid and comfort to ufferers from both diarrhea and s discomforts because it contains aolin and pectin *plus* belladonna lkaloids (as in Donnatal®).)onnagel treats the whole diarrhea problem. Available on your prescription or recommendation.

For acute, non-specific diarrheas
Donnagel® -PG (Donnagel with paregoric equivalent).
Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children.
See product literature before prescribing.

A. H. Robins Company
Richmond, Va. 23220

A·H·ROBINS


CLEAR THE TRACT! ROBITUSSIN®
50 3141

THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . . 100 mg.
Pheniramine maleate . . . . . . 7.5 mg.
Codeine phosphate . . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HANO

A. H. Robins Company, Richmond, Va. 23220

A-H-ROBINS

Smoking - Health Council, Physicians Help New PTA Educational Thrust

BY PETER HOHEISEL
OF THE MSMS STAFF

How to stop young people from becoming cigarette addicts is the problem to which the Michigan Council on Smoking and Health and the Michigan PTA will address itself this fall and winter.

Leaders of the two organizations and a group of physicians who are helping to provide leadership believe that education is a solution.

"Parents must be clearly informed about what smoking does to the human being. In the PTA we believe it is the parent's responsibility to guard the health of their children. I have never met a parent who positively wanted his or her child to smoke," declares A. B. Haist, state PTA president.

"We want, through the PTA and Smoking Council effort, to give parents the know-how and the proper attitudes to help them teach their children not to smoke."

To accomplish this the PTA will sponsor 14 regional workshops around the state during October and November. They will be designed to reach representatives from each of the 2,200 local PTA chapters in Michigan.

The meetings will involve a talk by a physician on the effects of smoking; a talk by a psychologist on the psychological and social effects of smoking; and a talk by a health agency person. Representatives will go home to their local PTA's with a leadership kit which will spell out concrete steps to waging the war against smoking.

"Doctors can be active in this campaign," counsels Henry J. Vandenberg, Jr., M.D., of Detroit, "by placing literature in their waiting rooms about smoking."

Doctor Vandenberg is the MSMS Representative to the Council on Smoking and Health and feels strongly that physicians can have an enormous influence in the anti-smoking war. "I never tell patients not to smoke," he says, "I tell them what it is doing to them and what they can expect if they stop smoking."

Doctor Vandenberg is enthusiastic about the PTA program because, "Parents will be the most effective influence with their children. They have day to day contact with them and can do much to educate their kids about the dangers of smoking."

Benjamin Yep, executive secretary of the Smoking Council, is realistic about the possibility of getting adults to stop smoking. But he is still optimistic that parents who continue to smoke can do much to teach their children not to smoke.

If parents can't shake the habit he recommends they tell their children something like this: "I got into the habit when I was young. At that time we didn't know so clearly how dangerous smoking is. Now we do, and that's why I don't want you to start. I can't quit the habit, but I wish I could. If you don't start you will never have the habit."

"I'm out to make smoking socially unacceptable because it is a health hazard," declares Mr. Yep, who is coordinating a joint project of the Michigan Council and the Michigan PTA.

Purpose of the joint effort is to influence young people to never start smoking. Each day, Mr. Yep points out, 4,500 young people light their first cigarette. Many keep on lighting up.

Last year, 20 states adopted the National PTA's recommendation for a major Anti-Smoking campaign. This year twenty more states, including Michigan, followed suit.

Mrs. Charles Palmer, Parma, is chairman for the PTA project. The Michigan PTA this year has a planned program of work in five areas of concern. Herbert A. Auer, of the MSMS staff, is general chairman for the state PTA Program of Work for 1967-68.

MSMS, AMA Join In College Lectures On Nutrition Topic

Edgar S. Gordon, M.D., Professor of Medicine at the University of Wisconsin Medical Center, will deliver five clinical lectures at Michigan colleges this fall on the topic of "Obesity Is a Metabolic Disease."

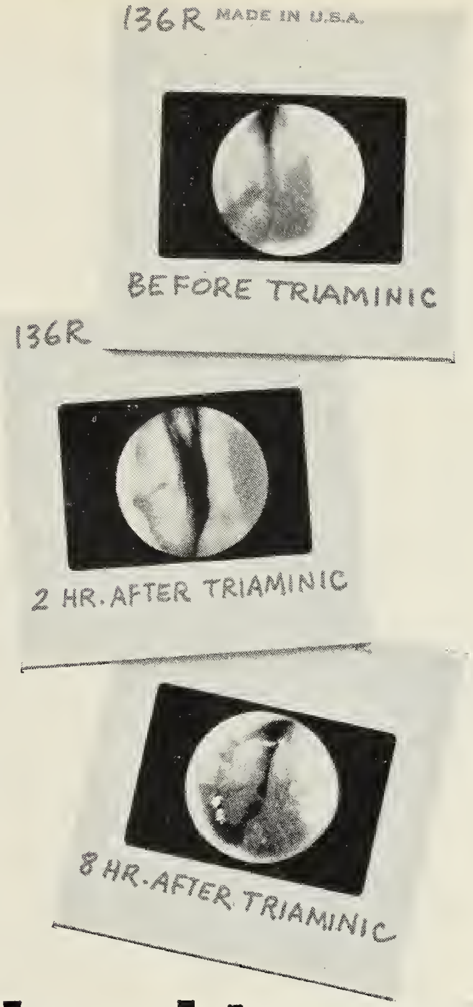
The series, beginning October 5 at Hope College in Holland, is co-sponsored by the Michigan State Medical Society and the AMA Council on Foods and Nutrition.

Doctor Gordon will speak at the colleges throughout the school year with the hope of stimulating students to consider careers in the health sciences, as well as informing the audience of advances in nutrition.

On October 30, Doctor Gordon will speak at Central Michigan University in Mount Pleasant and at Ferris State College in Big Rapids on October 31. The Northern Michigan and Western Michigan University dates are not set as yet.

Physicians in the area are invited to attend the lectures.

From a continuing study on nasal congestion . . .



timed to work while your patient does

A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

Begun in March 1966, the study to date has encompassed 85 patients with common nasal disorders—and measured their response to recommended doses of Triaminic tablets.

Timed to release its oral nasal decongestant and two antihistamines within 8 hours, Triaminic was found to effect partial or complete relief in better than 82% of the subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic *really* works.

Triaminic® *timed-release tablets*

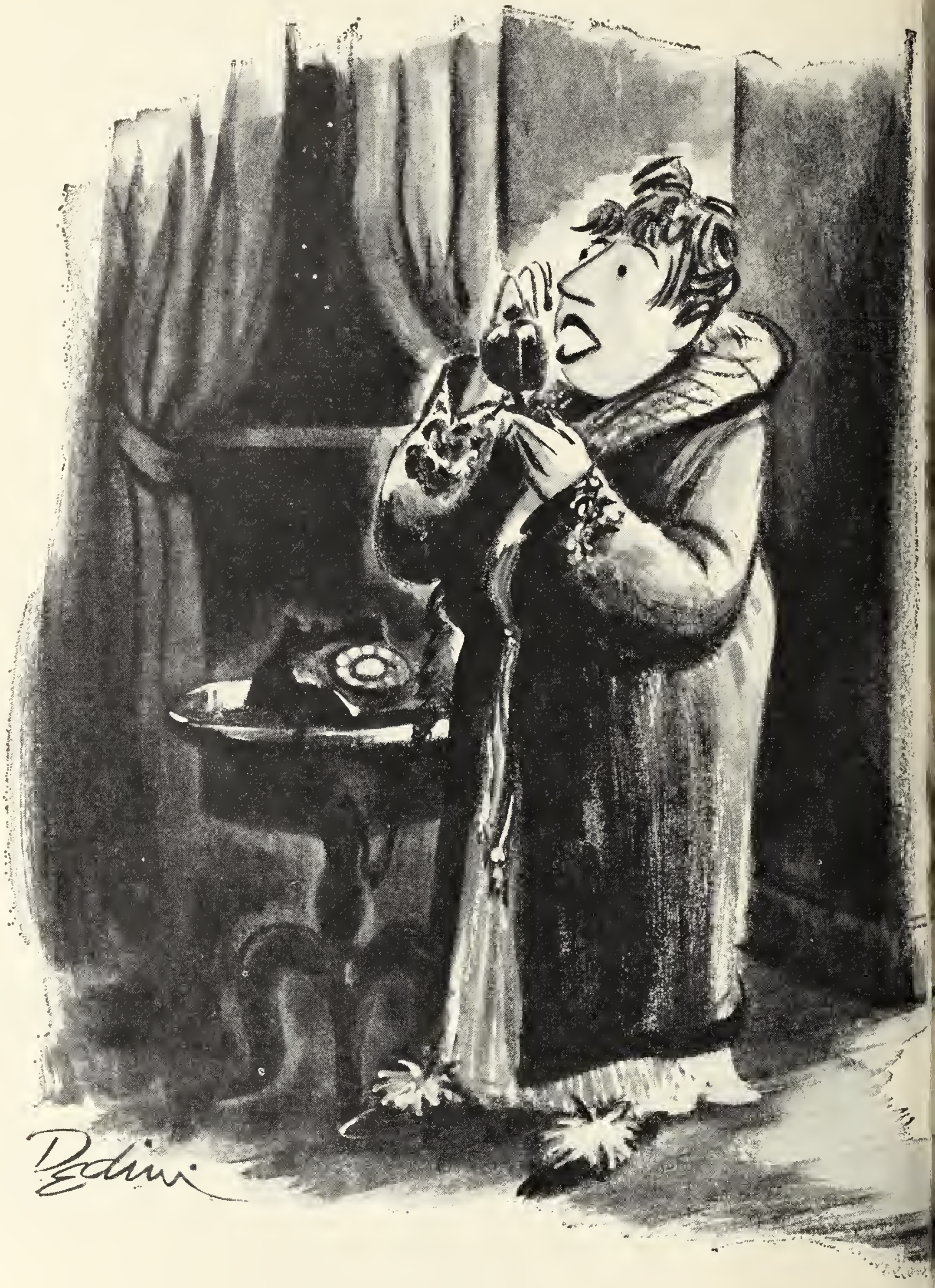
Each timed-release tablet contains:

Phenylpropanolamine hydrochloride .... 50mg. Pyrilamine maleate .... 25mg. Pheniramine maleate .... 25mg.

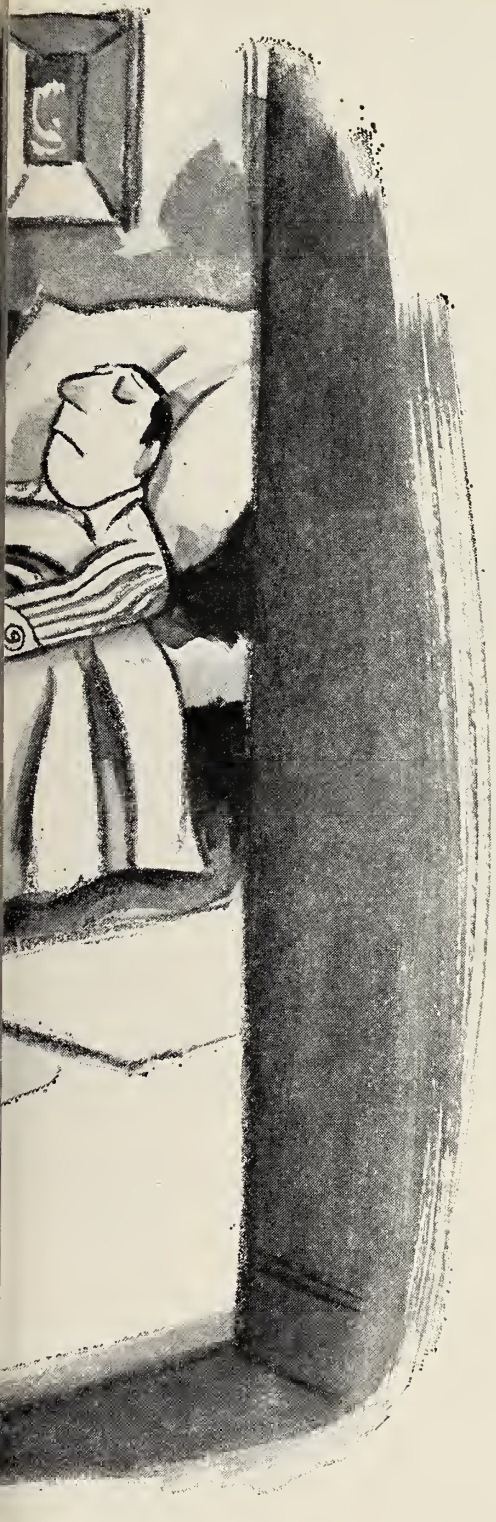
Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES • *a division of The Wander Company* • **LINCOLN, NEBRASKA 68501**



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

PR Survey Results Discussed At AMA Communications Institute

How can a medical society best communicate with its members?

An AMA poll, announced at the recent AMA Communications Institute, of county and state societies suggested the following four ways in order:

First — First-Class letters
Second — Newsletters
Third — Bulletins
Fourth — Meetings

The county and state society officials who answered the poll pointed out that first-class letters were excellent because they were fast and tended to be delivered directly to the physician and not sorted out by secretaries. Newsletters and bulletins (The poll did not indicate the difference) were favored by many societies because the copy was brief, and the publication was regular and inexpensive.

THE INSTITUTE program revealed the results of another poll which sought reactions to the question, "What do you believe is the most serious public relations problem for the medical profession and what do you see as solutions?"

The poll among county and state society officials found three problems popping up on most returns: (1) MD-Patient Relationships, (2) Medical Costs, and (3) Doctor Shortage.

The suggested solutions for medical public relations problems included the following:

1. Teach the public about the cost of quality care.
2. Make [illegible] public relations begin in the office.
3. Train office girls to be more sympathetic.
4. Teach communications to medical students.
5. Tell the public about the charity work done by doctors.
6. Explain all the facets of rising health care costs.
7. Develop long range plans to get more doctors.

ONE OF THE MAJOR speakers at the Communications Institute was Sam Lubell, public opinion specialist from New York City, who predicted "a tight squeeze next year for the medical profession." Mr. Lubell said people will become more sensitive to rising hospital costs. He challenged the medical profession to work to stabilize the costs rather than trying to push the blame off on others. Mr. Lubell suggested that the efficiency of the doctor might be improved.

"The country needs a program to stabilize medical care costs, and would be grateful if the medical profession moved into this field," he said.

(Note: Stories in the December issue will report further on this AMA Institute)

AMA PRESIDENT Milford O. Rouse, M.D., told the Institute that, "We cannot gain the understanding we need of our problems, nor the cooperation we need from our fellow citizens in solving them, if we do not make ourselves more a part of the leadership of the community."

"As in so many other instances, the question

(Continued on Page 1326)

"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.

BAYER
ASPIRIN
FAST PAIN RELIEF
ORANGE FLAVORED
BAYER
ASPIRIN
FOR
CHILDREN

CONTINUED: AMA INSTITUTE

boils down to this one: not 'Can we take the time to do a civic job?' but 'Can we possibly afford not to do so?' "

Doctor Rouse continued:

"Making oneself available for wider participation in the life of the community can take many forms. Basically, however, it means dealing with other people. Of course we see the citizens of our community. We see them as our patients. But too often we fail to see our patients as citizens of the community.

"We can correct that by taking part in the activities in which they take part.

"We can broaden the circle of people we invite to our social functions and can accept more of the social invitations we receive in turn. Many important movements within a community have had their beginning at a back yard cookout or around a dinner table.

"Further, we can become active members of civic clubs and service organizations . . . social, business or interprofessional fraternities . . . and other such organizations.

"We can participate more actively in both the deliberations and the sleeves-up work of the political party to which we give our allegiance.

"We can encourage our medical assistants to join their local, state and national organizations; and we can support the Woman's Auxiliary.

Before swinging into action to lead one of recent AMA Communications Institute workshops, Jack Brown, left, AMA field representative for Michigan, and Brock F. Brush, M.D., Detroit, MSMS Public Relations Committee chairman, are stopped by the photographer. Doctor Brush was a workshop leader and Mr. Brown, his recorder.

"There is a real question in my mind as to whether we can continue to merit the respect we need from our fellow citizens if we continue in large numbers to hold ourselves aloof from the problems which beset the community as a whole."

MSMS WAS WELL represented at the Communications Institute. C. Allen Payne, M.D., then the MSMS president, was there as was B. M. Harris, M.D., the new president.

Brock E. Brush, M.D., Detroit, Chairman of the MSMS Committee on Public Relations, was chosen as one of the leaders for an important afternoon discussion group. H. Clay Tellman, M.D., Muskegon, Vice-Chairman of the PR Committee, also participated.

Others from Michigan included C. A. Wilkinson, M.D., Grand Rapids; Robert E. Medlar, M.D., and John M. McLaughlin, M.D., both of Jackson; Stanley M. Mesirow, M.D., and John T. Manning, M.D., both of Benton Harbor, and Herman J. Heinemann, M.D., of Flint.

Several county society executive secretaries participated, including Carl G. King, Saginaw County; William G. McClimans, Kent County; and Mrs. Ruth Garnsey, Genesee County.

John A. Doherty, Executive Secretary of the Michigan Health Council, participated.

MSMS staff representatives included Hugh W. Brenneman, Warren E. Tryloff, Richard Campau and Herbert A. Auer.

MSMS PR Chairman Brush, after the Institute, said:

"I believe that we should seriously consider the first-class News Letter whenever important news occurs. If it is used only for significant events it should be read by all physicians. I am going to recommend to our Medical Society that we continue our work on: 1. Health careers; 2. Attempt to be more helpful in the Community Action programs.

"I believe that we should examine neighborhood health centers and the programs of the Office of Economic Opportunity and attempt to be more helpful in these areas."

Doctor Wilkinson, Secretary of the Kent County Medical Society, offered these observations after the Institute:

"The Institute was very worth while in presenting ideas from widespread areas over the country on how to improve our PR and communications. The most helpful items were those methods discussed for presenting information to various members of the society such as bulletin boards and radio and television communications.

"The other facet of the Institute which interested me, but somewhat depressed me, was the report of various members regarding interjection

(*Continued on Page 1329*)

one step
ahead

Times change and classic lobar pneumonia rare. Your next pneumonia patient may have atypical clinical picture and perhaps a thogen in his sputum such as *H. influenzae* *Mycoplasma pneumoniae* (Eaton Agent), hich is believed to be responsible for one out every five cases of pneumonia. That's why it akes sense to keep one step ahead—and preribe the *true* broad-spectrum antimicrobial tivity of DECLOMYCIN.

With DECLOMYCIN, you get effective ac- n against *both H. influenzae* and *Mycoplasma* ıeumoniae, plus prolonged high levels of antiotic activity in the blood and the lung tissue. ɔu're one step ahead with...

ECLOMYCIN®
EMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page

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ıRTH WRITING FOR:

PHYSICIAN AND HOME CARE SERVICES:

ıblished by the United States Department of lth, Education and Welfare. Copies available request from: Michigan Health Council, Box East Lansing, Michigan 48823.

NDARDS OF ACCOUNTING AND ANCIAL REPORTING FOR VOLUNTARY LTH AND WELFARE ORGANIZATIONS:

eveloped jointly by the National Health Coun- nd the National Social Welfare Assembly. An erstandable, uniform, and comparable way of rting financial affairs to the public. Copies lable from: National Health Council, 1790 ıdway, New York, New York 10019. $5.75 , lower in quantity.

GESTIONS FOR A COMMUNITY RDINATED HOME CARE PROGRAM:

eveloped by the Michigan Health Council. ies available on request from: Michigan Health ncil, Box 431, East Lansing, Michigan 48823.

CONTINUED: AMA INSTITUTE

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For a wide range of everyday infections—respiratory, urinary tract and others— in the young and aged—the acutely or chronically ill.

For common and unusual pneumonia

DECLOMYCIN Demethylchlortetracycline should b equally or more effective therapeutically than other tetra cyclines when the offending organisms are tetracycline sensitive.

Contraindication: History of hypersensitivity to demethy chlortetracycline.

Warning—In renal impairment, usual doses may lead t excessive accumulation and liver toxicity. Under suc conditions, lower than usual doses are indicated, and, therapy is prolonged, serum level determinations may b advisable. A photodynamic reaction to natural or artif cial sunlight has been observed. Small amounts of dru and short exposure may produce an exaggerated sur burn reaction which may range from erythema to sever skin manifestations. In a smaller proportion, photo allergic reactions have been reported. Patients shoul avoid direct exposure to sunlight and discontinue drug a the first evidence of skin discomfort. Necessary subse quent courses of treatment with tetracyclines should b carefully observed.

Precautions—Overgrowth of nonsusceptible organism may occur. Constant observation is essential. If new in fections appear, appropriate measures should be taken In infants, increased intracranial pressure with bulgin fontanels has been observed. All signs and symptom have disappeared rapidly upon cessation of treatment

Side Effects—Gastrointestinal system—anorexia, nausea vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pru ritus ani. Skin—maculopapular and erythematous rashes A rare case of exfoliative dermatitis has been reported Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose re lated. Hypersensitivity reactions—urticaria, angioneuroti edema, anaphylaxis. Teeth — dental staining (yellow brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the dru during the neonatal period, infancy and early childhood Enamel hypoplasia has been seen in a few children. I adverse reaction or idiosyncrasy occurs discontinue med ication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 m b.i.d. Should be given 1 hour before or 2 hours afte meals, since absorption is impaired by the concomitan administration of high calcium content drugs, foods an some dairy products. Treatment of streptococcal infec tions should continue for 10 days, even though symp toms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 15 mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCI
DEMETHYLCHLORTETRACYCLIN

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New Yo

Lederle

and usurpation of our functions in medical care by the OEO.

"It would seem to me after hearing the views expressed in this Institute that perhaps the biggest and most important project of all in the coming year is to educate the press and to present our views and our suggestions, fairly and realistically."

Doctor Medlar, President-Elect of the Jackson County Medical Society, declared:

"Perhaps the most comforting thing we learned at the AMA Communications Institute was that our problems are no different from the problems of all other medical societies and that our basic approach is approximately the same. What is essential is leadership and hard work at improving communications between doctors, their societies and the public.

"Whatever we do we need to remain organized in order to continue to fight for the preservation of our medical system.

"An orientation pamphlet for new members and new officers which would be fairly standard would be helpful and this could include a listing of the reasons why membership in organized medicine is valuable."

AMA Communications Efforts Described

(Editor's Note: The following is excerpted from an address by F. J. L. Blasingame, M.D., Executive Vice President, AMA, to the recent 1967 AMA Communications Institute.)

"When the AMA reports on its communications, the problem is not one of shortage. No organization, no association, no profession does more to communicate with its members as well as with the public.

"The massive effort of the American Medical Association includes:

"1. The AMA News is sent each week to every physician in the United States. At the present time, that figure is just over 311,000. In addition, this publication goes to every member of Congress, every junior and senior medical student, to libraries, to many newspaper editorial writers, to radio and television stations, to the executives of chambers of commerce, and to hospital administrators and others.

"2. The *Journal of the American Medical Association* goes to every member of the AMA each week.

"3. The 10 medical specialty journals also reach thousands of physicians.

"4. The American Medical Association sponsors approximately 1,000 meetings a year, large and small, on scientific and socio-economic subjects. The AMA sends participants or observers to about an additional 1,000 meetings each year.

"5. The AMA publishes 12 newsletters.

"6. There are 650 motion pictures available to members from the AMA and others, plus more than 100 exhibits.

"7. The AMA publishes several books a year and more than 800 pamphlets, reprints, reports, proceedings, catalogs, kits, and speeches are available to AMA members.

"8. The AMA staff received more than 30,000 letters a week and sends out some 40,000 pieces of mail every week, while answering more than 1,000 telephone calls a day.

"9. During 1966, the AMA staff handled close to 800 pamphlet orders a day and shipped out more than 23 million pamphlets.

"10. The AMA archive-library handles between 12 and 18 hundred requests a month, and staff members make hundreds of appearances every year before medical societies and physician groups.

"11. *Today's Health* magazine, with a circulation of 700,000 copies including 300,000 on display in physicians waiting rooms.

"12. The AMA communications effort also includes news releases, radio and television public service announcements, motion pictures, press conferences and interviews, speeches made by our officers, trustees, and others."

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SUGGESTIONS FOR A COMMUNITY COORDINATED HOME CARE PROGRAM:

Developed by the Michigan Health Council. Copies available on request from: Michigan Health Council, Box 431, East Lansing, Michigan 48823.

MSMS Offers Clinic Programs, Lectures in 18 Cities this Fall

Eighteen post-graduate courses are being offered across Michigan this fall by the MSMS Committee on Postgraduate Medical Education. MSMS members are urged to attend the meeting in their locality.

"The importance of continuing education to doctors cannot be overestimated," states Harry A. Towsley, M.D., Ann Arbor, Chairman of the sponsoring MSMS Committee. "The post-graduate lectures are one of the best ways a doctor can update his knowledge," Doctor Towsley adds.

The following programs have been scheduled this year:

LOWER PENINSULA

ALPENA, OCT. 25

Afternoon Clinic

Dinner Meeting: Roland G. Hiss, M.D., U-M, on "Management of the Common Anemias" and David W. Watson, M.D., U-M, on "Ulcerative Colitis."

BATTLE CREEK, OCT. 3

Dinner Meeting: Robert H. Gregg, M.D., WSU, on "Respiratory Emergencies in Children."

GRAYLING, OCT. 18

Dinner Meeting: Herbert E. Pedersen, M.D., WSU, on "The Peacetime Amputation Problem" and Ralph Coskey, M.D., WSU, on "Dermatologic Aspects of Collagen Disease."

HOLLAND, NOV. 3

Afternoon Clinic: Thomas A. Bruce, M.D., WSU; Stewart E. Pursel, M.D., WSU.

Dinner Meeting: Doctor Bruce on "Medical Aspects of Cardiac Surgery," and Doctor Pursel on "Surgical Aspects of Cardiac Surgery."

LANSING, OCT. 17

Dinner Meeting: Stuart M. Finch, M.D., U-M, on "Adolescent Psychiatry."

MIDLAND, NOV. 16

Afternoon Clinic: Reed O. Dingman, M.D., U-M; F. Bruce Fralick, M.D., U-M; E. Richard Harrell, M.D., U-M; Reed M. Nesbit, M.D., U-M; Harry A. Towsley, M.D., U-M; Walter P. Work, M.D., U-M.

Dinner Meeting

MUSKEGON, OCT. 18

Afternoon Clinic: Richard O. Kraft, M.D., U-M.

NILES, OCT. 17

Dinner Meeting: George H. Lowrey, M.D., U-M, on "Endocrine Disturbances in Children."

PETOSKEY, NOV. 9

Afternoon Clinic

Dinner Meeting: William R. Olsen, M.D., U-M, on "Shock," and Neal A. Vanselow, M.D., U-M, on "Advances in the Field of Allergy."

TRAVERSE CITY, NOV. 14

Dinner Meeting: John A. Penner, M.D., U-M, on "Hemorrhage and Thrombosis."

UPPER PENINSULA

ESCANABA, OCT. 17

Afternoon Clinic

Dinner Meeting: Ananda S. Prasad, M.D., WSU, on "Current Problems of Anemia," and Robert Wilson, M.D., WSU, on "Pathogenesis and Treatment of Shock."

HOUGHTON, OCT. 16

Afternoon Clinic

Dinner Meeting: Thomas J. DeKornfeld, M.D., U-M, on "Inhalation Therapy," and S. Martin Lindenauer, M.D., U-M, on "Treatment of Recurrent Pelvic Neoplasm."

IRON MOUNTAIN, OCT. 18

Afternoon Clinic

Dinner Meeting: Thomas J. DeKornfeld, M.D., U-M, on "Inhalation Therapy," and S. Martin Lindenauer, M.D., U-M, on "Treatment of Recurrent Pelvic Neoplasm."

IRONWOOD, OCT. 17

Afternoon Clinic

Dinner Meeting: Thomas J. DeKornfeld, M.D., U-M, on "Inhalation Therapy," and S. Martin Lindenauer, M.D., U-M, on "Treatment of Recurrent Pelvic Neoplasm."

MANISTIQUE, OCT. 17

Luncheon Meeting: Ananda S. Prasad, M.D., WSU, on "Current Problems of Anemia," and Robert Wilson, M.D., WSU, on "Pathogensis and Treatment of Shock."

MARQUETTE, OCT. 19

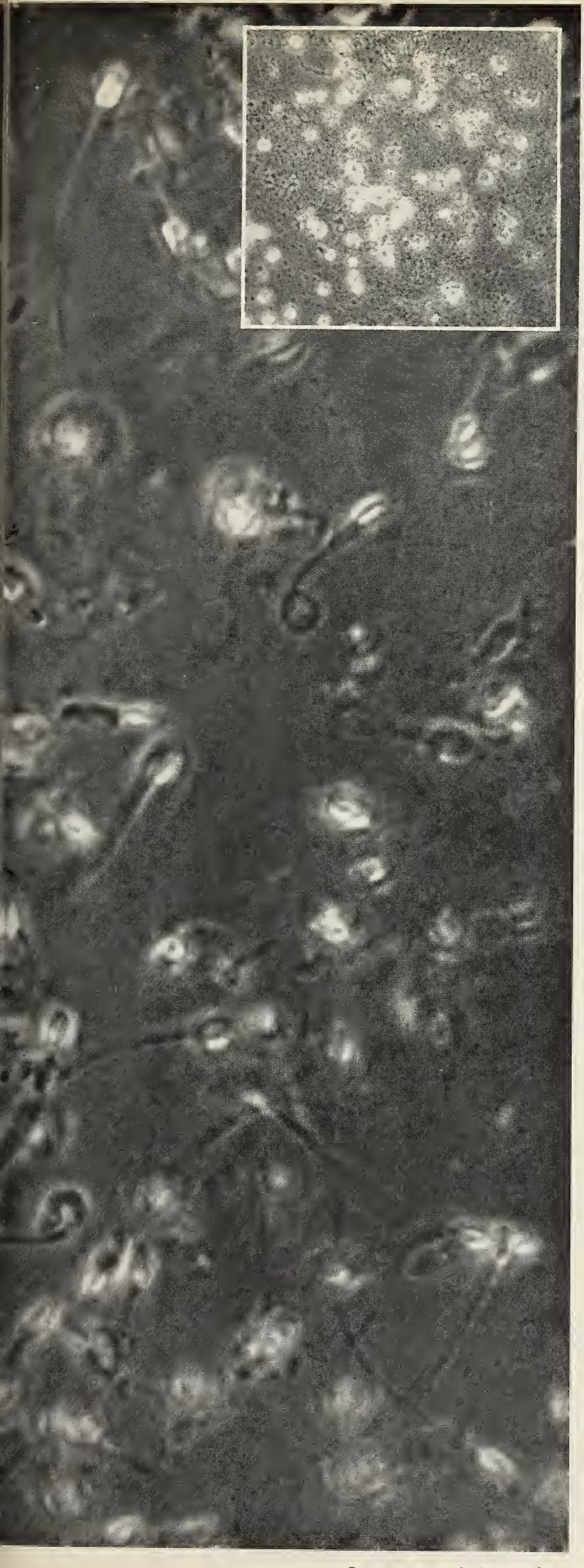
Dinner Meeting: Thomas J. DeKornfeld, M.D., U-M, on "Inhalation Therapy," and S. Martin Lindenauer, M.D., U-M, on "Treatment of Recurrent Pelvic Neoplasm."

MENOMINEE, OCT. 18

Afternoon Clinic: Ananda S. Prasad, M.D., WSU, on "Current Problems of Anemia," and Robert Wilson, M.D., WSU, on "Pathogenesis and Treatment of Shock."

SAULT STE. MARIE, OCT. 16

Dinner Meeting: Ananda S. Prasad, M.D., WSU, on "Current Problems of Anemia," and Robert Wilson, M.D., WSU, on "Pathogenesis and Treatment of Shock."



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1 — a combination of both low-dosage progestogen and estrogen for the full treatment cycle — may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual midcycle picture of a thin, watery cervical mucus. The result — a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

The role of viscous cervical mucus as a secondary action of Norinyl-1

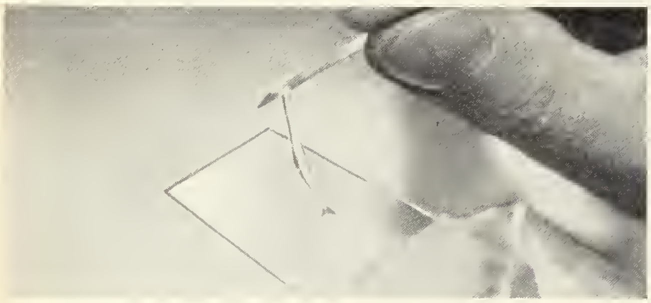
In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

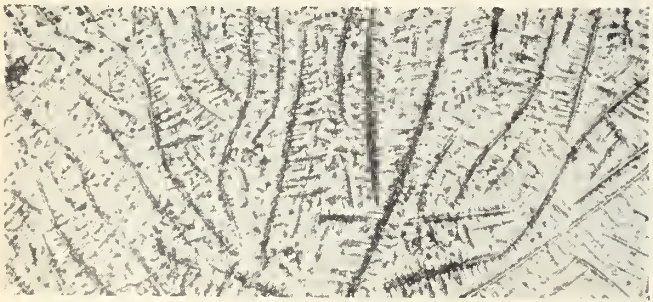
---

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

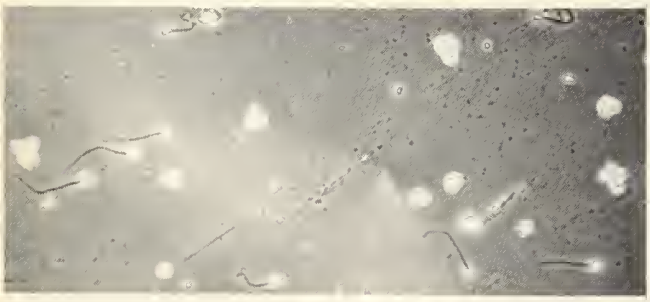
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

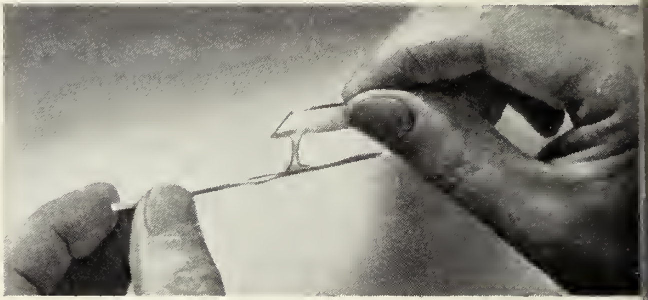


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

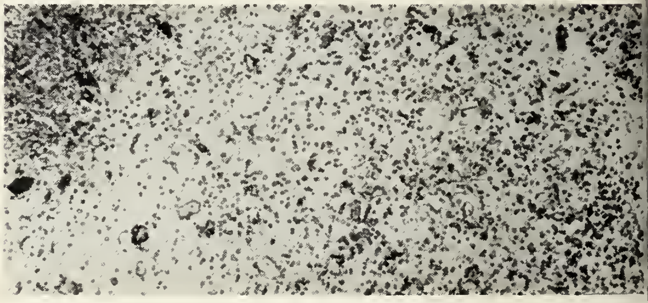


Spermatozoa appear healthy, are active and freemoving.

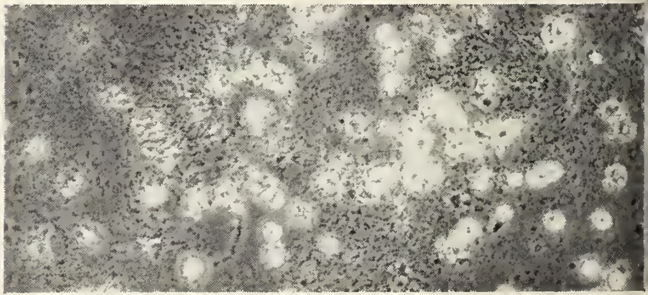
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

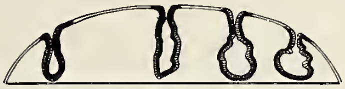


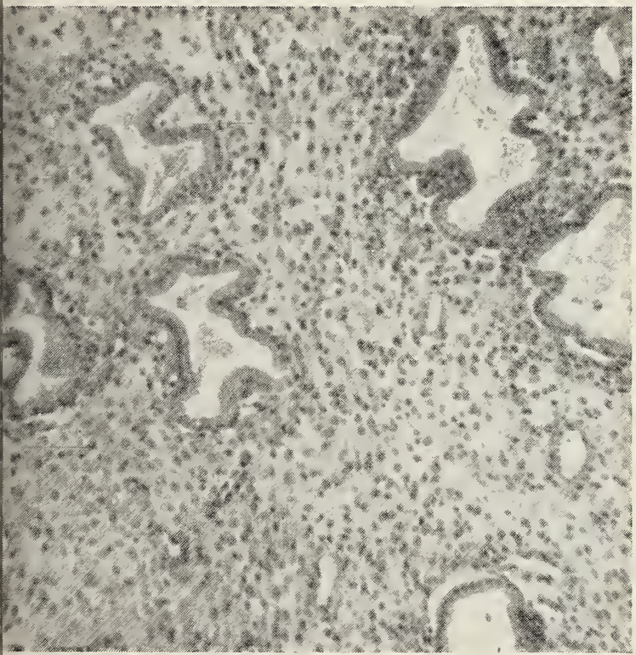
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

ow Norinyl-1
lters normal
ndometrial responses–
nother possible
rotective mechanism

us suppose that an ovum is released—as occurs in an
asional, rare case—and somehow a sperm succeeds in
etrating the cervical mucus barrier. Should this come about,
additional action of Norinyl-1 may protect the patient
m unwanted pregnancy. The theory is that progestogen intake
kes endometrial tissue unreceptive to implantation.

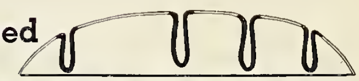
dometrium of
treated patient

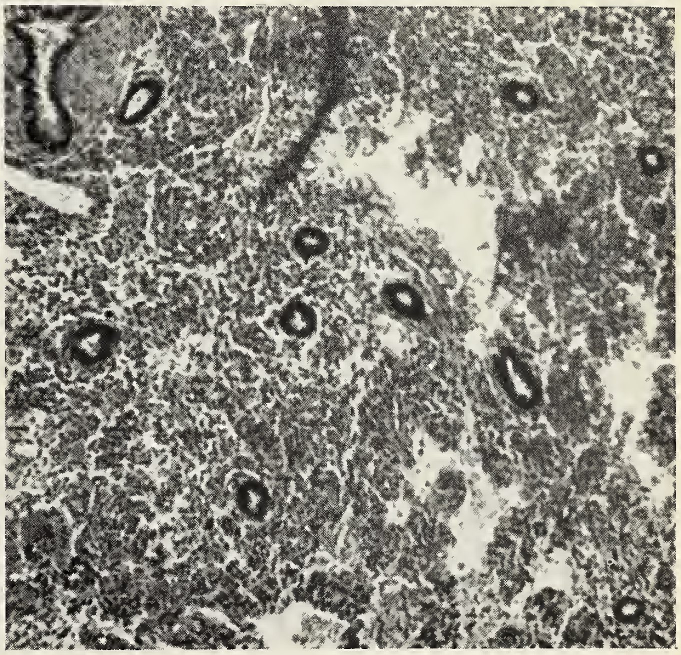




rmally, the endometrium progresses through
proliferative phase stimulated by estrogen and a
cretory phase stimulated by progesterone.
ring the secretory phase the endometrium is
eptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl®-1 tablets

(norethindrone 1mg. c̄ mestranol 0.05mg.)

last page for contraindications, precautions, side effects and dosage.

effective fertility control on half the previous dosage

maintains ratio of the established norethindrone/mestranol combination

lower cost

new Norinyl®-1 tablets

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Reduction of oral contraceptive dosage to lowest effective levels h
become a well-accepted principle of conservative medical practi
In keeping with this view, Norinyl is now available in a new streng
in which *both* norethindrone and mestranol are reduced 50 perce
Studies show that Norinyl-1 achieves fertility control with only 1.
mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent
human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg.,
an oral contraceptive, is currently in use by over 2,000,000 wom
Clinical experience now establishes that Norinyl-1 also amply mee
the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptives:
creased bromsulphalein retention and ot
hepatic function tests, coagulation tests
crease in prothrombin, factors VII, VIII, IX
X), thyroid function (increase in PBI and b
nol extractable protein-bound iodine and
crease in T^3 values), metapyrone test, pregn
diol determination.

Other side effects reported to have occur
in association with use of this drug are d
ness, hirsutism, pains in legs, back, chest
abdomen, dysuria, drowsiness, vaginal
charge, libido increased and decreased, e
tions, hypermenorrhea, hypomenorrh
increased appetite, G.U. infections, varic
veins, abdominal fullness, acne, heada
nervousness, allergies, blurred vision, pain
eyes, and itching in eyes. *For complete clini
data, see package insert.*

Dosage and Administration: 1. One tablet
Norinyl-1 is administered orally for 20 d
beginning on day 5 of the menstrual cy
(Count day 1 of the cycle as the first day
menstrual bleeding.) Repeat this dosage sch
ule for each cycle. 2. If no menstrual per
occurs after a cycle of treatment (20 tablets)
which patient adhered to the schedule, the
tient must be instructed to resume taking
Norinyl-1 tablets 7 days after the previous
day course was completed. For example, if
last pill of a previous cycle had been taken
a Sunday, then a new cycle of treatment sho
begin on the following Sunday. 3. In the p
partum woman, it is recommended that
first cycle of treatment should begin on da
of the first menstrual cycle. However, Norin
should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1
with mestranol 0.05 mg.)—Dispensers of 20 a
60 and bottles of 250 tablets.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

U-M Postgraduate Courses Announced

The following courses are being offered during he 1967-68 academic year.

Further information about each course is available from Harry A. Towsley, M.D., Department of Post-graduate Medicine, W5610 University Hospital, Ann Arbor, Michigan 48104.

Continuing Courses

Allergy, Clinical: The Atopic Disease, Mar. 11-3, 1968.

Blood Coagulation, Mar. 18-22, 1968.

Cancer, Some Problems in the Diagnosis and Treatment of, May 1-3, 1968.

Diagnosis, A Symposium of Bedside and Office Signs and Symptoms, Dec. 6-9, 1967.

Electrocardiographic Diagnosis, Apr. 8-11, 1968.

Endocrinology & Metabolism, Feb. 12-16, 1968.

Heart, Diseases of the, Jan. 22-26, 1968.

Infectious Diseases: The Current Concepts in Diagnosis and Treatment, May 16-17, 1968.

Medical and Surgical Emergencies, The Mangement of, Mar. 18-20, 1968.

Medical Problems, The Diagnosis and Treatment of Some Common (Northern Michigan course), June 17-21, 1968.

Nuclear Medicine, Mar. 4-6, 1968.

Renal Disease, Hypertension and Vascular Diseases, Feb. 19-23, 1968.

Therapeutics, Recent Advances in, May 20-24, 1968.

Thyroid, Diseases of the, May 13-14, 1968.

Neurology, Clinical, Nov. 6-7, 1967.

Obstetrics and Gynecology, Jan. 29-31, 1968.

Ophthalmology Conference, Apr. 24-26, 1968.

Otorhinolaryngology Conference, Apr. 4-6, 1968.

Otorhinolaryngology for Generalists, Nov. 30-Dec. 2, 1967.

Pediatrics, Clinical, Feb. 26-28, 1968.

Physical Medicine—Practical Uses of Electromyography, Feb. 1-2, 1968.

Physiology, Application of Principles to Clinical Medicine, Feb. 5-9, 1968.

Psychiatry—The Management of Psychosomatic Problems, Oct. 19-20, 1967.

Radiology, Recent Advances in Diagnostic, Mar. 27-29, 1968.

Special Courses for Sesquicentennial Year, Leukemia-Lymphoma, International Conference on, Oct. 9-13, 1967.

Arthritis, Prognosis for. Rheumatology Research Today and Prospects for Tomorrow, Nov. 9-10, 1967.

Genetics in Medicine (American College of Physicians), Nov. 26-29, 1967.

Basic Sciences and Their Clinical Correlation

Pathology, Oct. 2-Dec. 15, 1967.

Surgical Anatomical Review, Apr. 8-May 17, 1968.

Continuing Pathology Seminars on Neoplasia, Sept. 7, 1967; Nov. 16, 1967; Feb. 22, 1968; Apr. 25, 1968.

Intermittent Courses

Clinical Internal Medicine (Thursday afternoons), Sept. 7-Dec. 21, 1967.

Electrocardiography & Heart Disease (Tuesday evenings), Oct. 3, 1967-Jan. 16, 1968.

Anatomical Review (Thursday afternoons), Jan. 18-May 2, 1968.

Selected Clinical Topics in Internal Medicine (Tuesday evenings), Jan. 23-Apr. 23, 1968.

Clinical Internal Medicine at Wayne County General Hospital (Wednesdays), Oct. 4-Dec. 20, 1967; Jan. 3-Mar. 20, 1968.

Home Study Course in Electrocardiography

30 weeks beginning, Oct. 1, 1967; Jan. 1, 1968; Apr. 1, 1968.

DOW

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OPPORTUNITIES
for PHYSICIANS

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Applicants with good general medical knowledge and strong interest in research sought for expanding research departments. Will organize, arrange and evaluate clinical investigation of pharmaceuticals and biologicals. Research background desirable but not essential.

Excellent solories commensurate with background. Company paid relocotion expenses to Indianopolis.

Send full details
of qualifications in
strict confidence to:
A. Kaloyanides, Mgr.,
Technical Placement

PITMAN-MOORE
DIVISION
THE DOW CHEMICAL COMPANY
1200 Modison Ave. Indionopolis, Indiona
An Equal Opportunity Employer

Many Michigan physicians going to the AMA Clinical Convention November 26-27 will land at Houston's International Airport, a 1240-acre tract southeast of Houston. A new and modern administration building, three large fingers for loading and unloading of passengers and traffic, several hangars and buildings used in servicing airplanes and as classrooms are located on the field. Headquarters of the Texas National Guard are located in the southwest corner of the field.

Four PG Courses Offered by AMA at Houston Convention

HOUSTON — Physicians will have an opportunity to continue their postgraduate medical education at courses offered during the American Medical Association's Clinical Convention here November 26-29.

The postgraduate program, expanded to four subjects this year, offers courses in "Fluid and Electrolyte Balance," "Oncology," "Cardiovascular Disease," and "Obstetrics and Gynecology."

Leading medical educators will lecture at the courses, which will consist of three half-day sessions each.

The courses will be limited to 200 persons each; the first 200 who register on arrival in Houston will be given tickets. There will be a special Postgraduate Course registration booth adjacent to the general registration area in Astro Hall.

Courses will begin promptly at 9 a.m. and 2 p.m.

The AMA Convention program will offer refreshing insights into clinical problems that will be useful in practice or professional duties.

Major Conclave Soon On Family Planning

Many MSMS members will participate in the international "Fertility and Family Planning: A World View" conference at the University of Michigan November 15-16-17.

The Conference will be one of the highlights of the U-M 150th Anniversary.

S. J. Behrman, M.D., program chairman, declares, "We hope, therefore, that *all* interested persons will attend the conference, contributing to and gaining valuable information from the discussion of one of today's most critical problems — the world's population."

The conference will be divided into five sessions, the first session beginning on the afternoon of November 15 and the last session ending the afternoon of November 17. Each session will deal with a different aspect of population trends. There will also be a banquet for all participants and attendees on November 16th, at which John D. Rockefeller, III, will speak on "The Citizen's View of Public Programs for Family Limitation."

Doctor Behrman explains, "Each session of the conference will include the presentation and discussion of the papers designated for that particular session. Although the papers will *not* be read, they *will* be critically reviewed and summarized by a major discussant. A panel composed of the authors, the major discussant, and other distinguished scholars will then review and discuss the papers in detail. Free discussion between the audience and panel, directed by a moderator, will then be encouraged. In order to facilitate this free discussion, preprinted copies of the papers will be made available to the attendees for a nominal fee. These papers, along with the edited discussion of the conference will be available after the conference in book form."

Topics for discussion November 15 include "Fertility Trends in the Modern World"; on November 16 "Some Causes and Consequences of Fertility Trends" and "The Biologic Aspects of Fertility Control"; and on November 17 "Public Programs for Family Planning" and "Fertility Planning in the Developing World During the Next Decade."

Interested MSMS members may obtain conference details from Samuel J. Behrman, M.D., Director, Center for Research in Reproductive Biology, 2288 University Hospital, Ann Arbor 48104.

A breakthrough
in the control of pain

Talwin®
brand of
pentazocine
(as lactate)

a potent injectable non-narcotic—
may be used in place of morphine
and other narcotic analgesics

A breakthrough in the control of pain

Talwin®

brand of
pentazocine
(as lactate)

a potent injectable non-narcotic—may be used in place of morphine and other narcotic analgesics

Talwin 30 mg. relieves pain usually as quickly and effectively as morphine 10 mg.*

- **whatever the intensity of the pain**
- **whatever the cause of the pain**
- **whatever the site† of the pain**
- **whatever the chronicity of the pain**
- **whatever the age†† of the patient**
- **without the liability of narcotics**
- **without the development of tolerance on prolonged use**
- **with less risk of severe respiratory depression than with morphine**
- **with less constipation**
- **with less urinary retention**

Clinical experience of more than 150 investigator with over 12,000 patients given varying dosages Talwin shows that this potent injectable analgesi is not a narcotic.

Talwin has less risk of severe respiratory depres sion, urinary retention, and constipation than mo phine—a great boon for postsurgical patients.

Talwin produces less nausea, vomiting and dia phoresis than meperidine.

Constipation and urinary retention are seldom problem with Talwin.

Very rarely do hallucinations or disorientation oc cur (0.1% each).

No significant hepatic, renal, hematopoietic or neu rologic disturbances have been reported.

Talwin is well tolerated even by the aged or very patients.

Used during active labor, its tolerance by th mother and newborn is comparable to meper dine's. As with all new drugs, Talwin should be use with caution in pregnant women and in women de livering premature infants.

Tolerance to the analgesic effect of Talwin has n developed with prolonged use.

Talwin gives significant relief of pain in from 15 20 minutes following I.M. or S.C. injection.

Talwin relieves pain usually for 3 hours or longe with a single injection; however, the duration ma sometimes be less than with morphine.

86 per cent of medical and surgical patients obtained excellent to good relief with Talwin 30 mg. administered parenterally

---

*Its duration of action may sometimes be less than that of morphine.

†Should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.

††Until sufficient experience is gained, Talwin should not be administered to children under 12 years of age

alwin
and of pentazocine (as lactate)
# sed for pain of all types

alwin has a wide range of sefulness in surgery

pes of surgical use	Number of patients	Efficacy				
		% Exc.	% Good	Exc. + Good	% Fair	% Poor
Preoperative	118	31	52	83%	15	2
Postoperative	914	58	28	86%	8	6
Pre- and postoperative	12	75	17	92%	0	8
Minor surgery	33	30	39	69%	0	31*
raumatic	14	64	29	93%	7	0
ental	33	67	24	91%	3	6

Total patients............1124

fficacy of 30 mg. Talwin I.M. and S.C. as related types of surgical use in a cooperative study

ta in files of Department of Medical Research, Winthrop Laboratories.

gh incidence of poor results in minor surgery is due primarily to one udy involving change of burn dressings in children; 9 of 19 patients obined poor results with dose used.

alwin relieves all types f pain in acute and hronic medical disorders

pe of medical pain	Number of patients	Percentage of relief				
		Excellent	Good	Exc. + Good	Fair	Poor
Malignancy, pain in	161	44	37	81%	8	11
rthopedic; see also "Arthritis"	111	53	38	91%	5	4
ardiovascular pain; see also "Miscellaneous medical"	96	59	27	86%	6	7
enitourinary pain	83	42	33	75%	16	10
rthritis	76	33	51	84%	12	4
ynecologic pain	35	57	34	91%	6	3
ephalalgia	21	45	41	86%	9	5
astrointestinal pain	19	89	5	94%	0	5
hest, including • Pleurisy • Pulmonary embolism and infarct • Lung abscess	12	83	17	100%	0	0
Miscellaneous medical, including • Peripheral vascular disease • Thrombophlebitis • Cervical root pain • Facial neuralgia • Syringomyelia • Burns	108	50	39	89%	9	2

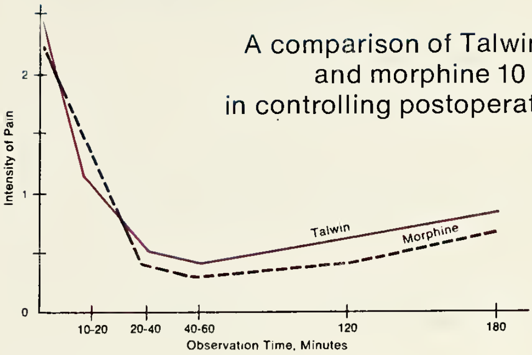
Total patients............722

fficacy of 30 mg. Talwin I.M. and S.C. as related o types of medical pain in a cooperative study

ata in files of Department of Medical Research, Winthrop Laboratories.

ee next page for additional product information

Talwin relieves pain as quickly as morphine



A comparison of Talwin 30 mg. and morphine 10 mg. I.M. in controlling postoperative pain*

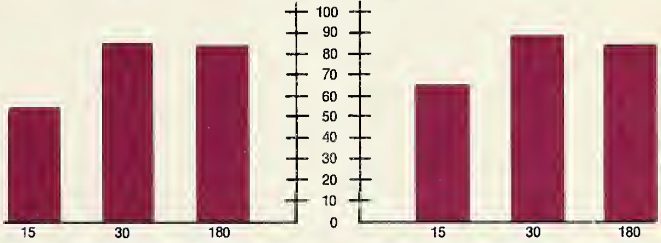
Figure 1.

Talwin 30 mg. proved equivalent to morphine 10 mg. in overall analgesic efficacy. During the early postmedication period (up to 40 minutes after drug injection), Talwin was superior in effect to morphine.

After observation periods ranging from 40 to 180 minutes there was no difference between the drugs in their effect on intensity. There were 141 and 119 complete patient records for Talwin and morphine, respectively, in this double-blind study. Other clinical investigators, studying duration, state that relief with Talwin may be obtained for up to three hours or longer, a period sometimes less than morphine's.

Talwin is as effective for severe pain (Fig. 2)† as for moderate pain (Fig. 3)†

Figure 2. **Figure 3.**



Minutes after administering Talwin

Per cent excellent to good relief of severe pain obtained with 30 mg. Talwin in 218 postoperative patients

Minutes after administering Talwin

Per cent excellent to good relief of moderate pain obtained with 30 mg. Talwin in 203 postoperative patients

Talwin does not require a narcotics prescription or narcotics records

The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally."‡

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*Storer, E. H.: Data in the files of the Sterling-Winthrop Research Institute.

†Cooperative study, data in the files of the Department of Medical Research, Winthrop Laboratories.

‡*World Health Organization Technical Report Series*, No. 343, 1966, p. 6.

A breakthrough in the control of pain

Talwin®

brand of
# pentazocine
(as lactate)

a potent injectable non-narcotic—may be used in place of morphine and other narcotic analgesics

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable sid effects associated with morphine, such as constipation, urinary reter tion, or severe respiratory depression. Furthermore, Talwin produce less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcuta neously, or intravenously, nausea, the most frequent adverse effec occurred in approximately 5.0 per cent. In decreasing order of oc currence were vertigo, dizziness or lightheadedness; vomiting; an euphoria. Respiratory depression was reported as an adverse reactio in 1.0 per cent.

The incidence of each of the other adverse effects was well belo 1.0 per cent: constipation, circulatory depression, diaphoresis, urinar retention, alteration in mood (nervousness, apprehension, depressio floating feeling), hypertension, sting on injection, headache, dr mouth, flushed skin including plethora, altered uterine contraction during labor, dermatitis including pruritus, dreams, paresthesia, an dyspnea occurred rarely after administration of Talwin (brand of pen tazocine). Furthermore, each of the following adverse reactions oc curred in less than 0.1 per cent: tachycardia, visual disturbanc (blurred vision, diplopia and nystagmus), hallucinations, disorienta tion, weakness or faintness, muscle tremor, chills, allergic reaction including edema of the face, taste alteration, insomnia, diarrhea cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adult (never apnea), even with large amounts. A small number of newbor infants whose mothers received Talwin during labor had transien apnea. The incidence of temporary diminution in the rate or strengt of uterine contractions is low after administration of Talwin, simila to that following meperidine hydrochloride. (In reporting no interfer ence with normal labor in patients receiving Talwin, one investigato further stated that the drug may increase uterine activity.) Generally no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have re vealed no significant abnormalities. A minimum and probably insignifi cant increase in the per cent of eosinophils in peripheral bloo counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and n changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Aver age recommended single parenteral dose is 30 mg., by intramuscular subcutaneous, or intravenous route; may be repeated every three t four hours. Pain has been relieved in most patients with not mor than three doses daily. Infrequently, selected patients have receive single doses as high as 60 mg.

Patients in Labor. A single, intramuscular 30 mg. dose has been mos commonly administered. An intravenous 20 mg. dose has given ade quate pain relief to some patients in labor when contractions becom regular, and this dose may be given two or three times at two- t three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in childre under twelve years of age is limited, the use of Talwin (brand of pen tazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwi for prolonged periods (e.g., over 300 days) experienced no with drawal symptoms even when administration was stopped abruptly furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with sol uble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has no produced apnea or severe respiratory embarrassment in adults, eve in large doses. Occasionally, however, moderate respiratory depres sion may occur. Means of maintaining proper oxygenation should b available in case of overdosage or respiratory depression, and methyl phenidate (Ritalin®) should be administered parenterally. The usua narcotic-antagonists, such as nalorphine, are not effective respirator stimulants for depression due to Talwin.

How Supplied: Ampuls of 1 ml., containing Talwin® (pentazocine) a lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, i Water for Injection. **Boxes of 10, 25, and 100.**

Multiple dose vials of 10 ml., each 1 ml. containing Talwin® (pentazo cine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodiu bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as pre servative, in Water for Injection. **Boxes of 1.**

The pH of Talwin solutions is adjusted between 4 and 5 with lacti acid and sodium hydroxide.

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New AMPAC Movies Offered County Societies

AMPAC is now offering three new political action films which will be of great benefit to physicians. They are:

(1) *A Congressman's Two Year Campaign for Re-election.* This is a 16 millimeter black and white film which runs for 29 minutes. It covers a two year period between election and re-election for a freshman incumbent in the House.

(2) *Managing the Campaign for the House of Representatives — The Public Relations Aspects.* Running time for the film is 18 minutes in 16 millimeter color.

(3) *Managing the Campaign for the House of Representatives — Working with Volunteers.* This film is also in 16 millimeter color and runs for 22 minutes.

Explanatory pamphlets accompany the latter two films. They should be booked well in advance. Physicians who would like to receive an order form should contact AMPAC, P.O. Box 152, East Lansing, Mich. 48823.

Many Michigan Men On AAP Program

Many Michigan physicians will be participating in the 36th Annual Meeting of the American Academy of Pediatrics in Washington, D.C., October 21-26.

Clifford D. Benson, M.D., of Detroit, will chair a discussion on "Vagotomy and Pyloroplasty in Infancy and Childhood."

Sathaporn Vathayanon, M.D., Donald R. Kahn, M.D., Aaron M. Stern, M.D., Joan M. Sigmann, M.D., Park W. Willis III, M.D., Burton L. Perry, M.D., Marvin M. Kirsh, M.D., and Herbert Sloan, M.D., all of Ann Arbor will discuss "Factors Influencing Mortality After Total Correction of Tetralogy of Fallot."

Clifford D. Benson, M.D., M. Wael Lofti, M.D., and A. Joseph Brough, M.D., all of Detroit will discuss "Colonic Atresia and Stenosis."

Frederico A. Arcari, M.D., also of Detroit, will moderate a panel discussion on "Another Look at Hernia, Hydrocele, and Abnormalities of the Testicle."

Jack Lapides, M.D., from Ann Arbor, and James M. Pierce, Jr., M.D., of Detroit, will be panelists on a discussion of "The Usefulness of Physiological Tests of Bladder Function in Children."

The film produced by Frederick J. Margolis, M.D., of Kalamazoo, called "Parent to Child About Sex," will be shown during the meeting.

Many Teachers Receive Smoking-Health Guide

More than 32,000 copies of the "Teacher's Resource Guide on Smoking and its Relationship to Health and Disease" have been distributed by the Michigan Health Council and the Michigan Council on Smoking and Health.

The Michigan Health Council serves as the coordinating organization for the Michigan Council on Smoking and Health. The publication will be revised and reprinted during the coming year.

Menominee Physicians In Cooperative Effort With Marinette Neighbors

Crossing state lines with a comprehensive mental health program is only one of the traditional barriers being broken by the newly formed Mental Health Service of Marinette and Menominee, Incorporated. This unique cooperative venture between two states, Michigan and Wisconsin, which links two counties, Menominee and Marinette, is the only known program of its kind in the United States.

Located at Marinette General Hospital, the Clinic has been operational since May 1. Its services are available to all Marinette and Menominee county residents regardless of age or type of psychiatric help needed.

The clinic follows the philosophy that community psychiatry is a community's effort to help itself, and the clergy, teachers, attorneys, physicians, nurses, law enforcement agencies, and welfare department workers can combine their talents for the community's good.

The Clinic seeks to emphasize the importance of caring for a patient in or near his home.

AAMA Spotlight On Betty Lou Willey

Betty Lou Willey, Port Huron, Speaker of AAMA's House of Delegates, will be one of the prominent Michigan medical assistants at the national meeting in Los Angeles, October 8-15. Mrs. Willey is the former president of the Michigan chapter and has held many other offices.

Another Michigan Medical Assistant who will be active at the meeting is Nelda Gasperson of Mount Clemens. Mrs. Gasperson, as chairman of the Awards Committee, will be presenting the 1967 awards.

In a recent issue of the *AAMA Bulletin,* the center spread showed Betty Lou in four of the photos from the recent AMA Convention where she was an honored guest.

Sustained circulatory, respirato and cerebral stimulation for th

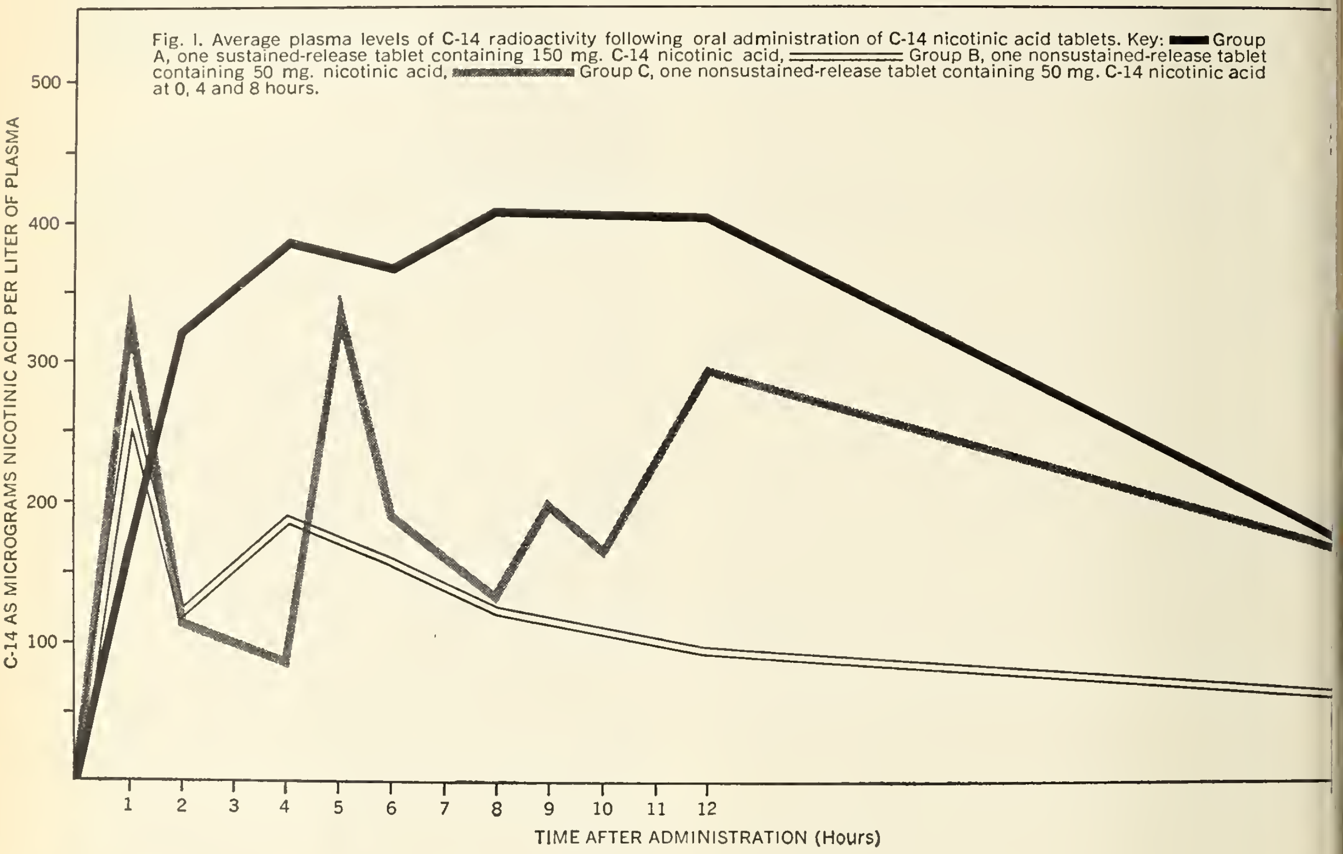

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be con tinuous on a daily dose of only one Geroniazol TT tab let every 12 hours.

The gradual release of nicotinic acid in Geroniazo TT will provide the well-known peripheral vasodilata tion needed in patients with deficient circulation an with a minimum amount (if any) of "flushing." Also cerebrovascular circulation is complemented by pen tylenetetrazol, long-established as a cerebral and res piratory stimulant.

Geroniazol TT improves the typical, unfortunate signs of senile confusion. Patients become more alert

ged and debilitated

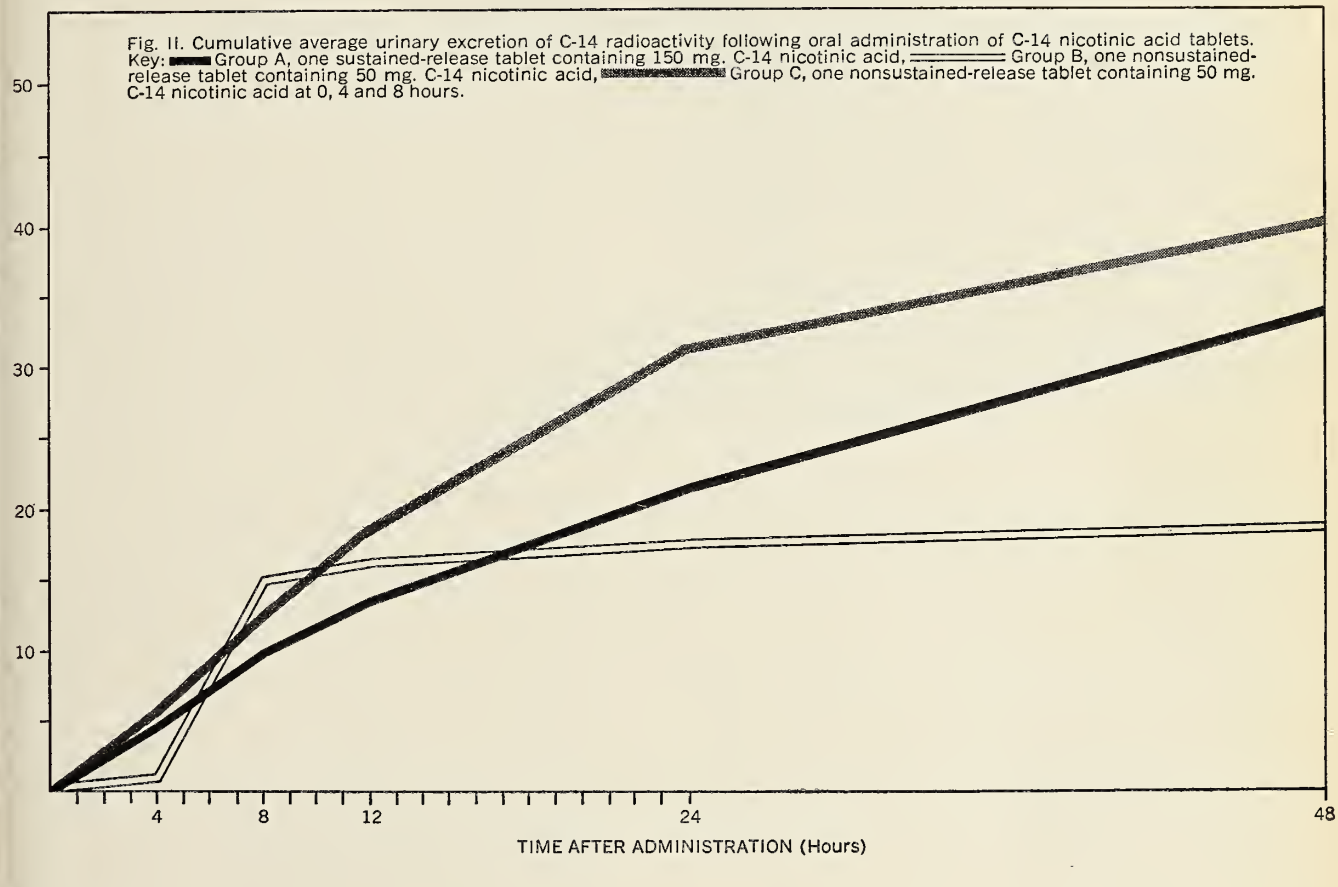

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▒ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ss confused and moody. Personal care, memory, motional stability, social attention improve. Fatigue, pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

ontraindications: There are no known contraindications.

recautions: Exercise caution when treating patients ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Branch, Swanson Join Army Colonel on TV; Talk about Viet Health

"We can and should be doing a lot more to give medical aid to South Vietnamese civilians," was the united contention of three prominent physicians who appeared recently on television in Lansing.

Spurgeon Neel, M.D., Colonel in the United States Army, Hira E. Branch, M.D., Flint, and Alfred Swanson, M.D., Grand Rapids, appeared as a panel on a MAP television show in Lansing. The discussion centered on "Vietnam Health" and was hosted by Hugh Brenneman, MSMS Executive Director, on Channel 6, WJIM-TV.

"Not only should the United States do much more for the Vietnamese civilians out of an obvious humanitarian motivation, but medical care is also a most effective way of winning the war for the peace and development of South Vietnam," said Alfred Swanson, M.D., a member of the panel who has made three trips to Vietnam on medical missions.

All the physicians agreed that the United States should increase its medical commitment to the civilian population of South Vietnam. At present the budget for medical care to civilians is only .02 percent of the total budget. As the number of civilian war casualties increases, the need for medical aid also increases.

"As physicians we must unite to speak out against the inadequate level of medical care being given to the South Vietnamese civilians," says Doctor Branch, panel member and chairman of the MSMS International Health Committee.

The MSMS Council this past Spring approved the view of the International Health Committee that much more medical aid is needed in South Vietnam.

Brown Installed, Hersey Next Leader For Health Officers

B. P. Brown, M.D., is the new president of the Michigan Health Officers Association which held its 23rd annual conference recently. Doctor Brown is Eaton County health director.

The following officers were also elected: Freeman Hersey, M.D., president-elect, Kalamazoo County health director; Robert Locey, M.D., secretary, health director of the Southwest District of Berrien, Cass, and Van Buren counties; Morris Reizen, M.D., treasurer, Ingham county health director.

Elected to fill an unexpired term on the association's board of directors was Florence Hampton, M.D., deputy health director of Wayne County.

Fralick Retains Association With U-M Medical Center

F. Bruce Fralick, M.D., Ann Arbor, associated with the University of Michigan Medical School for 40 years, has retired as chairman of the Department of Ophthalmology. Doctor Fralick will retain his association with the Department and will continue his practice of ophthalmology at the University Medical Center.

Commenting on Doctor Fralick's retirement, Medical School Dean William N. Hubbard, Jr., M.D., declared, "He has built a record of outstanding achievements, and as administrator, teacher, dedicated physician, and world-renowned ophthalmic surgeon has brought great distinction to the University of Michigan."

Doctor Fralick completed his undergraduate work at the University of Michigan and received his M.D. degree from the Medical School in 1927. He then joined the University Hospital staff as an intern, and except for one year at the University of Chicago Medical School, he has remained at the U-M. He has served as professor and chairman of the Department of Ophthalmology since 1936.

PARAPLEGICS LEARNING HOW TO DRIVE IN U-M COURSE

In a cooperative project at the University of Michigan Medical Center, paraplegics, amputees, and other handicapped patients are enrolled in a driver training program being introduced by the Michigan Division of Vocational Rehabilitation (DVR) in cooperation with University Hospital and Ann Arbor High School.

A 1967 Oldsmobile, donated by the manufacturer, has been equipped with an array of levers and switches which permit safe operation by patients with severely limited arm and hand movements. Program leaders hope by training handicapped people to drive their own cars again, they will make a big stride toward regaining their independence.

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State Comprehensive Health Planning Commission Named

Governor Romney by Executive Order 1967-7 has created the Comprehensive State Health Planning Commission which was designated as Michigan's official long-range health planning agency.

This Commission was established in conformance with federal regulations requiring the designation of the establishment of a single state agency, which may be an interdepartmental agency, with responsibility for the administration of the State's comprehensive health planning functions.

The creation of the Commission August 22 closely parallels, in basic concept, recommendations that had been previously made to the Executive Office by The Council and the Committee on Governmental Medical Care Programs.

The Commission will presently comprise the following members:

1. Director of the Department of Public Health
2. Director of the Department of Mental Health
3. Director of the Department of Social Services
4. Director of the Bureau of the Budget
5. Executive Assistant, Director of Program Development, Office of the Governor.

The Commission is authorized to make an application for Federal funds or other public or private sources for comprehensive health purposes. An Executive Secretary is to be employed to serve at the pleasure of the Commission with the Executive Secretary authorized to employ such staff as required. The general duties of the Commission would be to coordinate and review health planning efforts among governmental and non-governmental agencies, organizations and groups concerned with health services, facilities, and manpower, and shall formulate and update on a continuous basis a comprehensive health planning process.

Also created by the Governor's Executive Order is a Comprehensive State Health Planning Advisory Council that will be appointed by the Governor and will serve at his pleasure. This Advisory Council shall advise the Commission in the exercise of its powers, duties and functions, and a majority of the Advisory Council shall be composed of consumers of health services as well as representatives of governmental and non-governmental organizations and groups concerned with health.

The Governor's action is in compliance with requirements of Comprehensive Health Planning and Public Health Service Act of 1966, P.L. 89-749.

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ıyroid Association Holds ational Event at U-M

The University of Michigan was host to the an-ıal meeting of the American Thyroid Associa-on Sept. 14-16.

Some 300 physicians attended the international squicentennial Conference to hear nearly 40 ıpers.

The annual Van Meter Prize Award of $1,000 r the best essay on the thyroid gland this year as presented to Kenjior Inoue, M.D., of the de-ırtment of pharmacology, University of Texas, uthwestern Medical School, Dallas. His paper as titled "Sedimentation Pattern of Soluble Pro-in from Thyroids of Iodine Deficient Rats; Acute ffect of Iodide Injection."

inch, Mason, Jacob n TV: "Formula or Handling Mama"

"Young mothers are better prepared for mother-ood today than women of 30 years ago," agreed ree prominent physicians who appeared on a cent MAP "Formula" television program.

Teen-age mothers, however, do not make good others. "They feel they've been cheated out of eir own childhood," stated Stuart M. Finch, M.D., Professor of Psychiatry at the University of Michigan School of Medicine; Robert J. Mason, M.D., MSMS Council Chairman; and S. Sprigg Jacob, M.D., East Lansing pediatrician.

The three doctors appeared on a MAP television show called "Formula for Handling Mama," over WJIM-TV in Lansing. The program is hosted weekly by Hugh Brenneman, MSMS Executive Director.

While the doctors disagreed about how good a mother a divorced woman makes and other controversial points, they agreed that mothers who have physically or mentally handicapped children should treat those children just as they would normal children. "They should be as well dressed as other children and taken places where other children go," according to the three physicians.

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> —Charles A. Sprague, Editor,
> Oregon Statesman,
> In Quill, June, 1967

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AMA Judical Council Adopts Statement on Professional Courtesy

Some MSMS members may wish to clip and file the policy statement on professional courtesy, as adopted by the AMA Judicial Council June 17, 1967:

"The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

"Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

"The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy:

"1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

"2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

"3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

"4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him."

BLUE PLANS ADD 2 MILLION IN '66

The National Association of Blue Shield Plan reports that its 84 Blue Shield Plans in the Unite States, Canada, and Puerto Rico served over 7 million – more than one-third of the population

The Blue Shield Plans paid out over $1.4 billion in benefits during 1966, up $52 million from the previous year.

John W. Castellucci, NABSP president, said that while the majority increase in those served by Blue Shield involved government programs – primarily Part B, the supplementary medical-surgical portion of Medicare – there was a net gain of almost 2 million members in regular underwritten enrollment in 1966. Figures were just released recently.

"Many of the elderly who had left Blue Shield's underwritten rolls to move to Medicare returned with the purchase of complementary coverage to fill gaps in the Medicare program," Mr. Castellucci said.

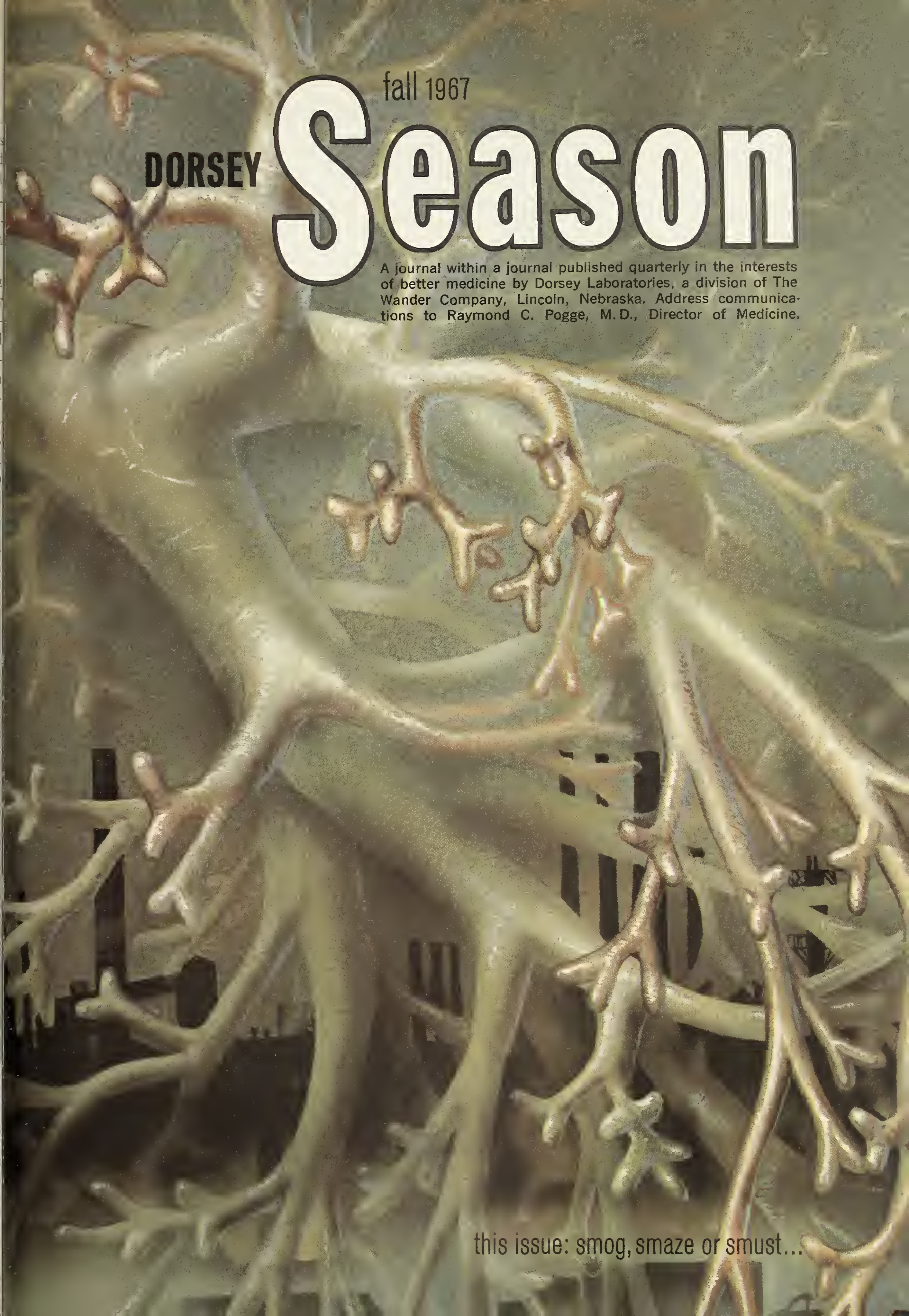
Today, Blue Shield Plans administer Title XIX programs in over ten states, while a majority of the other Blue Shield Plans have applied for Title XIX roles.

Mr. Castellucci reports an increasing movement is currently underway throughout Blue Shield toward paid-in-full programs based on the usual and customary fees of physicians. The common characteristic of these Blue Shield programs is that payments are based upon interpretation of the terms – usual, customary, prevailing, and reasonable.

CALIFORNIA OPINION RE MD-PHARMACIES

The California legislature has enacted a law which prohibits the Pharmacy Board from issuing new pharmacy permits to physicians and required all physicians to rid themselves from any membership, proprietary interest, or co-ownership in a pharmacy by June 1, 1967. On March 3, the District Court of Appeals held that this provision is constitutional. A number of medical clinics composed of licensed physicians, with clinic owned and operated pharmacies in conjunction with their activities, filed a petition for a declaratory opinion interpreting this statute as it might apply to them. The lower court held that the statute was applicable to medical clinics and medical group partnerships which own and operate pharmacies and that, as so construed, the statute was constitutional. This opinion was approved by the District Court of Appeals.

(from *The Doctor and the Law,* X, x, 3 [Aug. 67])



fall 1967

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M. D., Director of Medicine.

this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

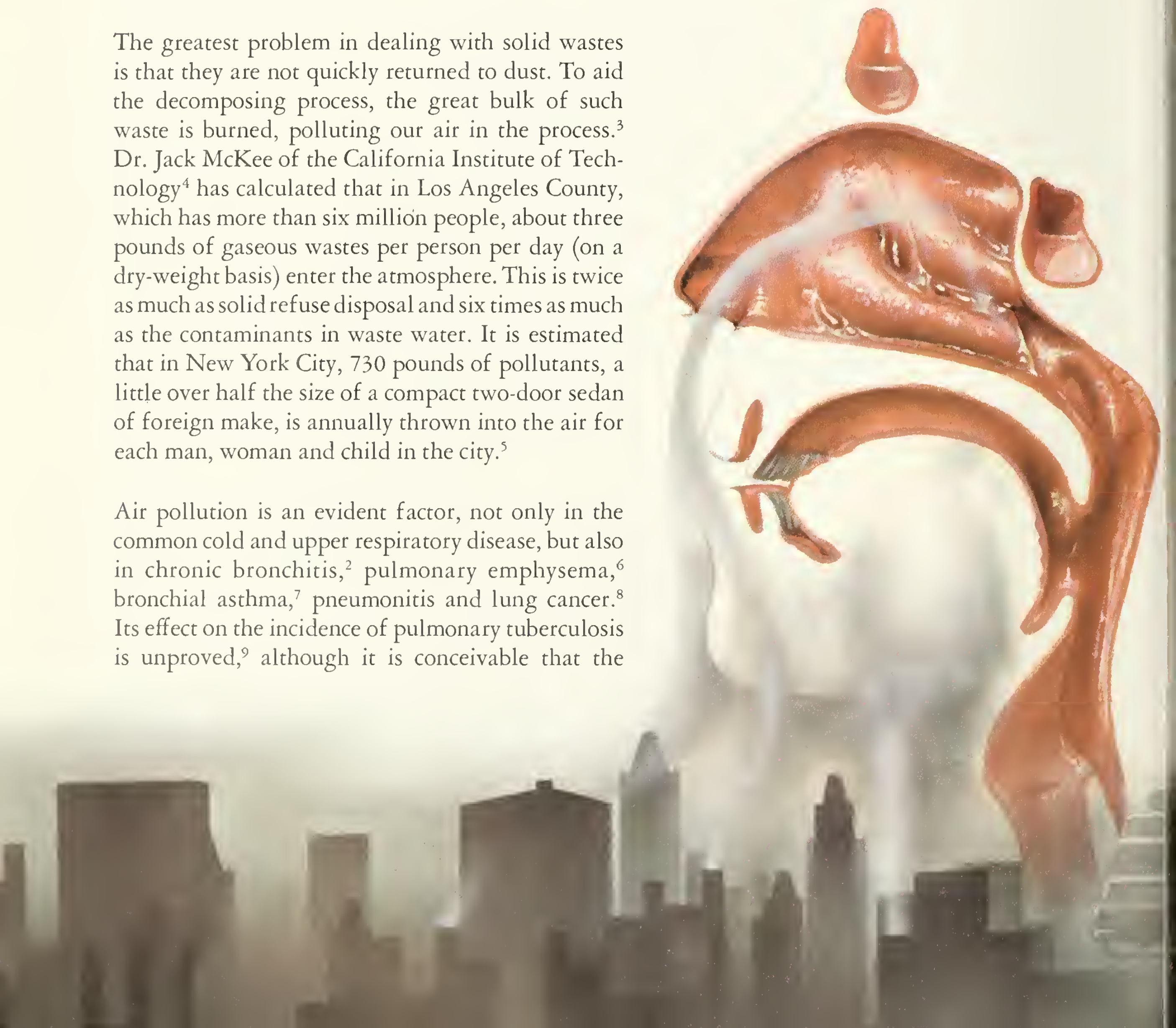
Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air mig do this. A siege of smog in Denver, the "mile hi city," in December 1965 was accompanied by res ratory infection that doubled normal absentee ra in schools, factories and city government.[10]

While air pollution is only one factor, it has becor important in the causes of most of the afflictions the respiratory tract. This has been shown not or by the Denver occurrence, but also by detailed stuc of respiratory illness in a small group of 313 m



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

For nature's hazards:
nasal congestion
due to seasonal
allergies and
summer colds

Triaminic® *syrup*

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion regardless of cause, you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these *side effects:* drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. *Precautions:* the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of antipollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

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How can he be a sport with a runny nose?

For summer allergies, summer colds, or nasal congestion due to almost any cause, you prescribe quick r-e-l-i-e-f with Triaminic. It's ideal for summer allergies:

1. Acts in 15-30 minutes due to decongestant.
2. Follows up with balanced dual antihistamines.
3. Up to 24-hour 'round the clock relief when dosed one tablet at morning, midafternoon and evening.

Summer time is sport time and who can be a sport with a runny nose?

provide patient comfort
Triaminic® relieves summer allergies

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitation, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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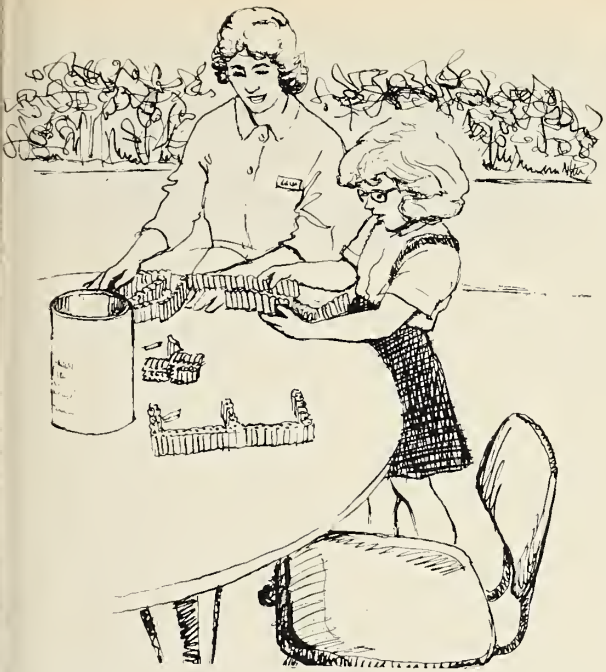

A rooftop patio for pediatric patients at the University Hospital at Ann Arbor was featured in the July issue of THE AUXILIARY LEADER, the journal for hospital auxiliaries. Made possible by the interest and contributions of a number of Michigan businessmen, the rooftop garden was formerly a drab concrete playcourt. Now it serves as a place for play and even outdoor picnics for the hospitalized children. It is furnished with flowers, trees, and shrubbery, and is manned by volunteers and hospital teachers who instruct and supervise the children in their games and schoolwork.

M.D. Placement

- Looking for a smaller town that needs and wants a physician?
- Do you need an associate or assistant in your practice?
- Are there towns in your area in need of additional physicians?
- If your answer is YES to any of the above questions, contact

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"*A Century of Service in Medicine* by Doctor Stapleton is indeed a beautiful addition to our library and an excellent treatise on the part of medicine in Michigan. We are proud to be among those who have received a copy."

R. E. Teagan, Vice President
S. J. Tutag & Company—Pharmaceuticals
Detroit

Dear Doctor:

It is with great pleasure that I invite you to my home state this fall, to the AMA Clinical Convention at Houston, November 26-29.

For you, the Clinical Convention presents opportunities for refreshing your medical knowledge, for renewing associations with fellow physicians, and for catching a breather from your busy schedule. It promises to be a stimulating four days, worthy of your time.

With my colleagues, the physicians of Texas and Harris County, I cordially invite you to Houston, a dynamic, interesting city that you and your family will enjoy.

This meeting is especially designed to help us keep up-to-date on latest medical developments. For the 21st consecutive year, the AMA has assembled an extensive, well-rounded program outlining current knowledge.

See you at the Clinical!

Milford O. Rouse, M.D.
President
American Medical Association

"After reviewing the book, I am certain that MSMS put a great amount of work into its development. I think it is very well done and represents the profession of medicine with great dignity."

—Robert C. Johnson, R.Ph.
Executive Director
State Pharmaceutical Association

53,000 DRUG STORES

Most of the prescription drugs consumed by the public are distributed through the nation's community pharmacies. An additional amount is dispensed by the nation's hospitals, and governmental health units. There are approximately 53,000 drug stores in the nation today with an average prescription volume per store of $59,000 per year.

Newspaper Headlines Helps Tell MSMS Stories

Michigan editors continue to utilize the news releases processed by MSMS to comment on health matters.

A good example was an article mailed in August, quoting the MSMS President who urged parents to get a pre-school examination early for their children.

Following are only a few of the headlines that appeared in papers across the state:

Port Huron Times:
DOCTOR ADVISES CHILDREN SHOULD HAVE EXAMINATIONS NOW

Clarksville Record:
PHYSICAL EXAM VERY IMPORTANT BEFORE SCHOOL

Petoskey News Review:
CHILDREN ENTERING SCHOOL THIS FALL NEED CHECK-UP

Big Rapids Pioneer Editorial:
AS WE SEE IT: IMPORTANT EXAM

L'Anse Sentinel:
PRE-SCHOOLER SHOULD HAVE PHYSICALS EARLY

Nashville News:
URGE PHYSICAL EXAMINATION FOR SCHOOL-AGE CHILDREN

Morenci Observer:
RECOMMEND PHYSICALS NOW FOR SCHOOL CHILDREN

OEO Finances Health Center for Detroit

The Herman Kiefer branch of Detroit General Hospital will be the site in 1968 for Detroit's first comprehensive medical and dental treatment center for the poor.

With a $2 million grant from the Federal Office of Economic Opportunity, the center expects to treat up to 15,000 persons in 1968.

George P. Sweda, M.D., head of the Health Department's hospitals and medical care division, said that the center will be a self-contained unit offering virtually all medical and dental facilities under one roof. Organization and construction of the health unit will be the responsibility of the Metropolitan Detroit Health, Research and Service Fund, Inc., a newly-formed non-profit corporation.

Detroit Health Commissioner John J. Hanlon, M.D., has said that the center will contain a full staff of physicians and specialists but care will be taken so its operation will not disrupt any private practice that doctors have in the area.

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

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AMA 21ST CLINICAL CONVENTION • ASTROHALL • HOUSTON, TEXAS • NOVEMBER 26-29, 1967

Plan to attend this year's AMA Clinical Convention in Houston, Texas. Eighteen scientific sessions, four postgraduate courses, breakfast roundtable discussions, color television, and scientific and industrial exhibits will bring you up to date on the latest medical advances. Attend lectures by, and discussions with, our nation's outstanding medical authorities.

Between sessions, enjoy the excellent restaurants, fine shops, visitors' attractions, and mild winter temperatures Houston offers. Mail the enclosed registration and room reservation coupons now, and look forward to an exceptional convention with a holiday plus.

SCIENTIFIC SESSIONS: Cardiovascular Disease; Cardiovascular Surgery; New Cares; Ophthalmology; Geriatrics; Arthritis; Gastroenterology; Cancer; Antibiotics; Endocrinology; General Surgery; Dermatology; Aerospace Medicine; Obstetrics and Gynecology; Psychiatry; Pediatrics; Genitourinary Diseases; and Otolaryngology.

POSTGRADUATE COURSES: Fluid and Electrolyte Balance; Oncology; Cardiovascular Disease; and Obstetrics and Gynecology. Register for these Courses on arrival in Houston at the PG Course Registration booth adjacent to the General Registration area. There is no charge for the Courses, but registration is limited to 200 per Course. The Courses begin promptly at 9 A.M. and 2 P.M. No one will be seated after the Course begins.

BREAKFAST ROUNDTABLE CONFERENCES: Management of Cerebrovascular Insufficiency; Indications and Limitations of Uses of Antibiotics; The Moral and Ethical Aspects of Caring for the Dying Patient; Adolescence, Age of Rebellion, Related Psychiatric Aspects.

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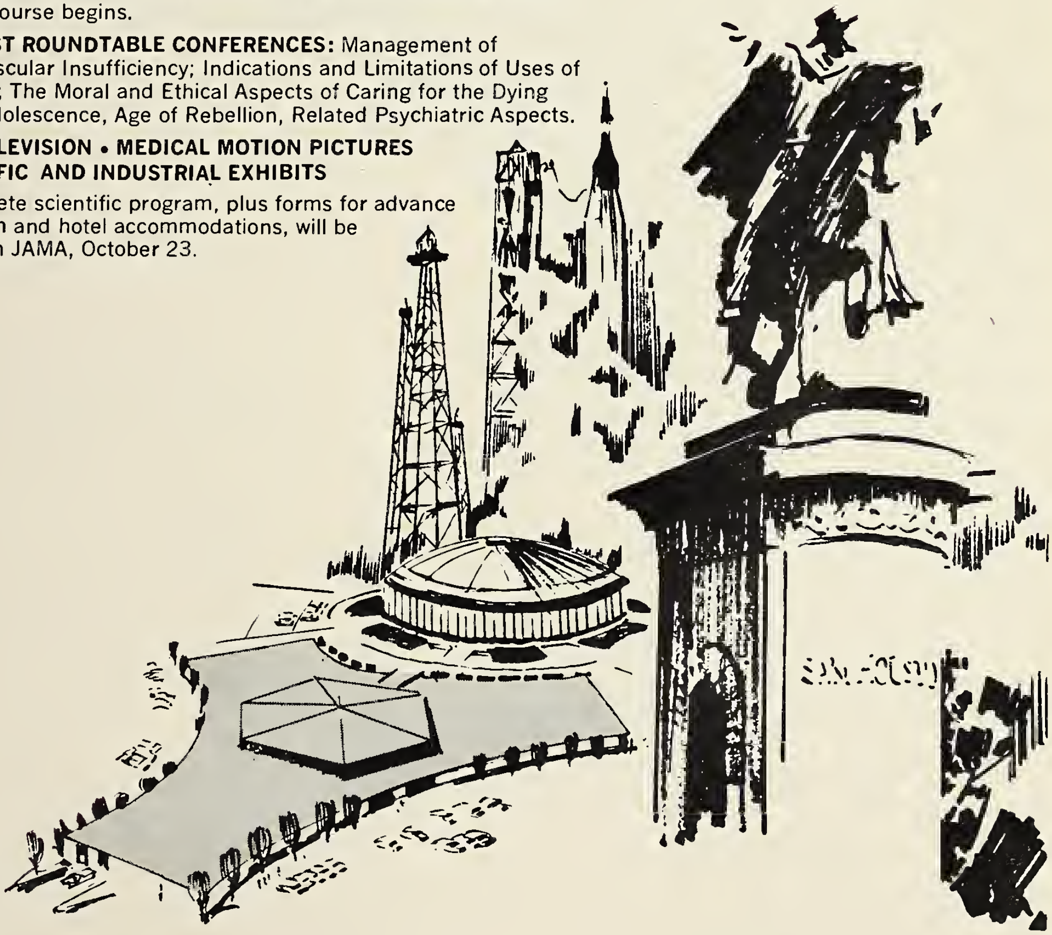
The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, October 23.



MSMS Supports Efforts for Beaumont Postage Stamp

"It is important for Michigan to be behind the effort to create a postage stamp commemorating Doctor William Beaumont because he did his basic research here on Mackinac Island," says Robert J. Mason, M.D., Chairman of the MSMS Council and Chairman of the Beaumont Memorial Committee, commenting on the decision of the MSMS Council, July 14, to join the Wisconsin State Medical Society in its petition to the Postmaster General to issue such a stamp.

The state medical societies of Connecticut, Vermont, and Missouri also are being asked to support the petition.

WMA Invites More Members

The World Medical Association, with its 500,000 member physicians, is open now to all members of the American Medical Association on an individual basis.

At present 60 national medical associations, including the AMA, are members of the WMA, which is a society for free national professional medical associations.

This year's conference was held September 10-17 in Madrid, Spain and the 22nd World Medical Assembly in 1968 will be held in Australia.

Chairman of the Council, governing body of the WMA, is Gerald D. Dorman, of New York. Doctor Dorman is also a member of the AMA Board of Trustees. Secretary General is Alberto Z. Romualdez, M.D.

To apply for individual membership, physicians should write to WMA Headquarters, 10 Columbus Circle, New York, N.Y., 10019, enclosing a check for $10 and a statement that the applicant is a member in good standing of the AMA. The applicant should also specify whether he wants to receive the *World Medical Journal* in English, Spanish, or French.

"The World Medical Association," said Doctor Dorman, "is uniquely qualified to act as a force for peace and understanding in the world today."

"The WMA," he continued, "is present at conference tables around the world where decisions are made affecting the practice of medicine, and where the practicing physician's free-enterprise viewpoint would not ordinarily be considered."

WMA has no connection with any government, Doctor Dorman added. It is committed to the philosophy that medical and scientific knowledge should be universally available and free of all political control.

Michigan community colleges are training more and more workers every term for the health team. Linda Dove, a Lansing Community College student enrolled in the Associate Degree Nursing Program, makes a catheterization lab presentation. This program is approved by the Michigan Board of Nursing. Graduates of this program will be eligible to take State Board examinations for licensure as registered nurses.

TREND AND PROJECTION OF BIRTHS STATEWIDE, 1965

YEAR	TOTAL BIRTHS**	POPULATION Age 15-44	BIRTHS PER 1000 In Age Group
1955	196,294		
1956	206,068		
1957	208,488		
1958	202,690		
1959	198,301		
1960	195,056	3,089,000*	63.1
1961	192,825		
1962	182,790		
1963	178,871		
1964	175,103		
1965	166,464	3,219,000*	51.7
1970	189,900***	3,485,000*	54.5***
1975	213,100***	3,863,000*	55.2***
1980	243,400***	4,238,000*	57.4***

* Data and estimates taken from **Working Paper No. 1,** State Resource Planning Program, Michigan Department of Commerce, January 1966. Prepared by Michigan Department of Public Health.

** Supplied by the Health Statistics and Evaluation Center, Michigan Department of Public Health

*** Gross Estimates

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.

**a stuffy nose
is no
laughing matter**

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

**each one can
give him all-day
or all-night relief**

SK&F Smith Kline & French Laboratories

removes the mental blur

that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL..............16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R)........65 mg.
Precaution: same as 16 mg. of phenobarbital

SUSTAINED SEDATION
AROUND THE CLOCK

Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING
WITHOUT PRESCRIPTION

AVAILABLE
Solfoton *(yellow, uncoated tablets "P")*
100s, 500s, 5000s
Solfoton Capsules *(yellow and brown)*
100s, 500s, 1000s
Solfoton S/C *(sugar-coated beige tablets)*
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> Reading as a medium is a superior stimulation to criticism, essential in the exercise of judgment, because readng requires active rather than passive participation.
>
> —Charles A. Sprague, Editor,
> Oregon Statesman,
> In Quill, June, 1967

MSMS States Position On Air Pollution

The MSMS Committee on Respiratory Diseases, chaired by Richard A. Rasmussen, M.D., of Grand Rapids, is also deeply concerned about air pollution and has drafted the following statement, approved by The Council:

"The Michigan State Medical Society, through its Committee on Respiratory Disease, officially endorses the principle of reasonable and scientific study directed toward the sensible control of the major problems of air pollution, whether this be the dusts or wastes of industry, the products of combustion of gasoline or oil (automobiles) or the combustion products of home heating and burning equipment, or of smoking tobacco. All of these may have potential effect on man via the respiratory system and are, therefore, of concern to the physician, especially as they are known to affect health adversely."

With increasing public sensitivity about the dangers of air pollution, the Michigan legislature, in Public Act No. 348, 1965, created an air pollution control commission within the state health department. Eight pages of Michigan law define air pollution, and what the commission can and cannot do to control it.

(Doctors interested in the complete law should write to MSMS, Box 152, East Lansing, 48823.

HODARI PAPER BEST AT MIDWEST CONCLAVE

A. Albert Hodari, M.D., from the Department of Obstetrics-Gynecology at Henry Ford Hospital in Detroit, won the 1967 Annual Prize Award at the September 13-16 meeting of the Central Association of Obstetricians and Gynecologists at the Sheraton-Cadillac Hotel in Detroit. Title of his paper was "The Contribution of the Fetal Kidney to Hypertensive Disease of Pregnancy."

The annual guest lecturer at the 35th annual meeting of the Association came from the University College at the Dublin National University of Ireland. He was Eamonn de Valera, M.D., who discussed "Technical Problems of Radical Vulvectomy."

Fantastic Days Ahead Assures Economist

"The projected growth of the nation's economy and personal incomes in the next 30 years," says J. Philip Wernette, Ph.D., University of Michigan economist, "will mean a tremendous increase in the discretionary expenditures of our people as the proportion of income that they have to spend on their necessities of life declines and the proportion left over for comforts and luxuries soars.

"The average American's standard of living will double within the next 30 years — and he will be buying fantastic products that do not even exist at present," the U-M economist predicts.

The U-M economist offers a dozen suggestions of new products, processes, and conditions that will affect our lives:

- Weather control
- Genuine cheap energy
- Personal aircraft
- New types of plastics replacing metals in many consumer and industrial products
- Cheap fresh water from the sea
- Artificial foods, resembling natural ones, but better
- Houses built quickly of foamed plastic, strong with high insulating properties and never needing painting.
- Wall-size TV screens.
- Pills for good health, good personalities, good dispositions, and emotional serenity.
- Space travel and exploration of the universe about us.
- New services provided by lending institutions

Dr. Wernette reports that the U.S. economy has grown from a 1790 population of 3.9 million and gross national product (in 1966 dollars) of about $1.5 billion to a 1966 population of 197 million and a gross national product of $740 billion.

He estimates that the American economy will pass the trillion-dollar annual rate (inflation factor excluded) in 1974. The rise will continue, he adds, and will probably double its present level in about 18 years.

This projection, of course, assumes that all goes well, says the U-M economist. He cites some of the conditions that people are worrying about today: a disastrous war; inflation; deflation and depression; the payments deficit and gold outflow; the national debt; a decline in the spirit of enterprise; mistaken governmental policies; creeping collectivism; exhaustion of natural resources, and moral and spiritual decay.

"Some of these things are grossly exaggerated as menaces," Professor Wernette concludes. "Others, however, are very real. It is our job to find solutions for the menacing ones."

WSU Psych Department Offers Wednesday Series

Emanuel Tanay, M.D., of Wayne State University Medical School's Department of Psychiatry, is giving a series of lectures at Sinai Hospital in Detroit on "Forensic Psychiatry."

The series, which began in September, is being given on Wednesday evenings at 7:30 in the 4-South area of the hospital. The last lecture will be November 1. Reservations must be made in advance. For information contact: Mrs. Packman, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit 48235.

What Is Health Like For Average Person? U.S. Survey Tells

Many statistics of interest to physicians are contained in a recent report about "the average American" by the federal government.

The following statistics are based on a sampling of households from July 1965 through June 1966, and are issued by the service's National Center for Health Statistics.

The average citizens spends 6.3 days a year in bed because of illness or injury.

If you are employed another requirement is staying home 5.8 work days because of illness or injury.

If you are a pupil between 6 and 16 and want to be average, a requisite is missing 5.2 days of school.

The disability days were just about the same as those for the previous year.

This meant an average of 2.1 acute conditions per person, about the same as in the preceding year.

The number of respiratory conditions increased 8.2 percent over the previous year, reflecting primarily the higher incidence of illnesses reported as influenza.

The report also noted a continued decline in infective and parasitic diseases and a drop in injuries.

The report said the 15 percent drop in injuries had not been explained despite extensive investigation. A person's chances of being injured during the year was about one in four.

The report was based on a sample of 42,000 households containing about 134,000 persons.

TODAY'S HEALTH GUIDE
SPECIAL FULL COLOR TRANSPARENCIES OF THE ORGANS AND SYSTEMS OF THE HUMAN BODY
A manual of health information and guidance for the American family
published by the AMERICAN MEDICAL ASSOCIATION

FOR YOUR PATIENTS:

Today's Health Guide is an up-to-date, 640-page, family health reference that should be in every home. The AMA's long awaited new book, Today's Health Guide, is the product of 200 of the world's most renowned authorities in medicine, science and allied fields.

The Guide discusses more than 2,000 illnesses, diseases and other medical subjects including diet and nutrition, child care, safety and first aid, sex education, mental health and when to seek professional medical attention. Over 300 striking illustrations and an eight-page full-color transparency of the human body vividly complement the text.

Today's Health Guide is the medical profession's answer to the need for an inexpensive yet authoritative and comprehensive home health guide.

Your patients may obtain one by sending a check or money order for $5.95 for each copy to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

HEARD THIS ONE?

A worker in the Social Security office initialled and passed on an official report, only to have it come back to his desk, with this note.

> "This document was not intended for your office. Please erase your initials and initial the erasure."
>
> *Chief Clerk*

He leaves to make an urgent call But doesn't use the phone at all

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).........(1.0 dram) 3.7 ml.
Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... ($2\frac{1}{2}$ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

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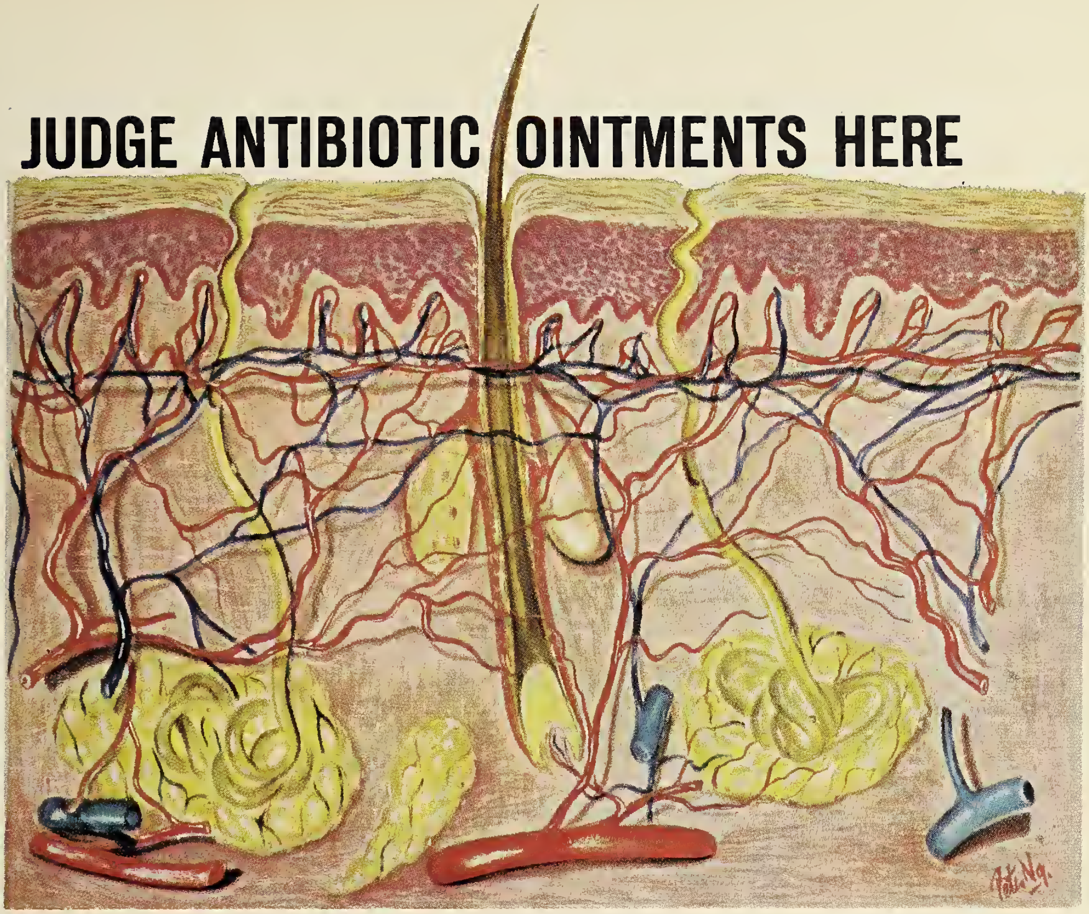

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.
Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

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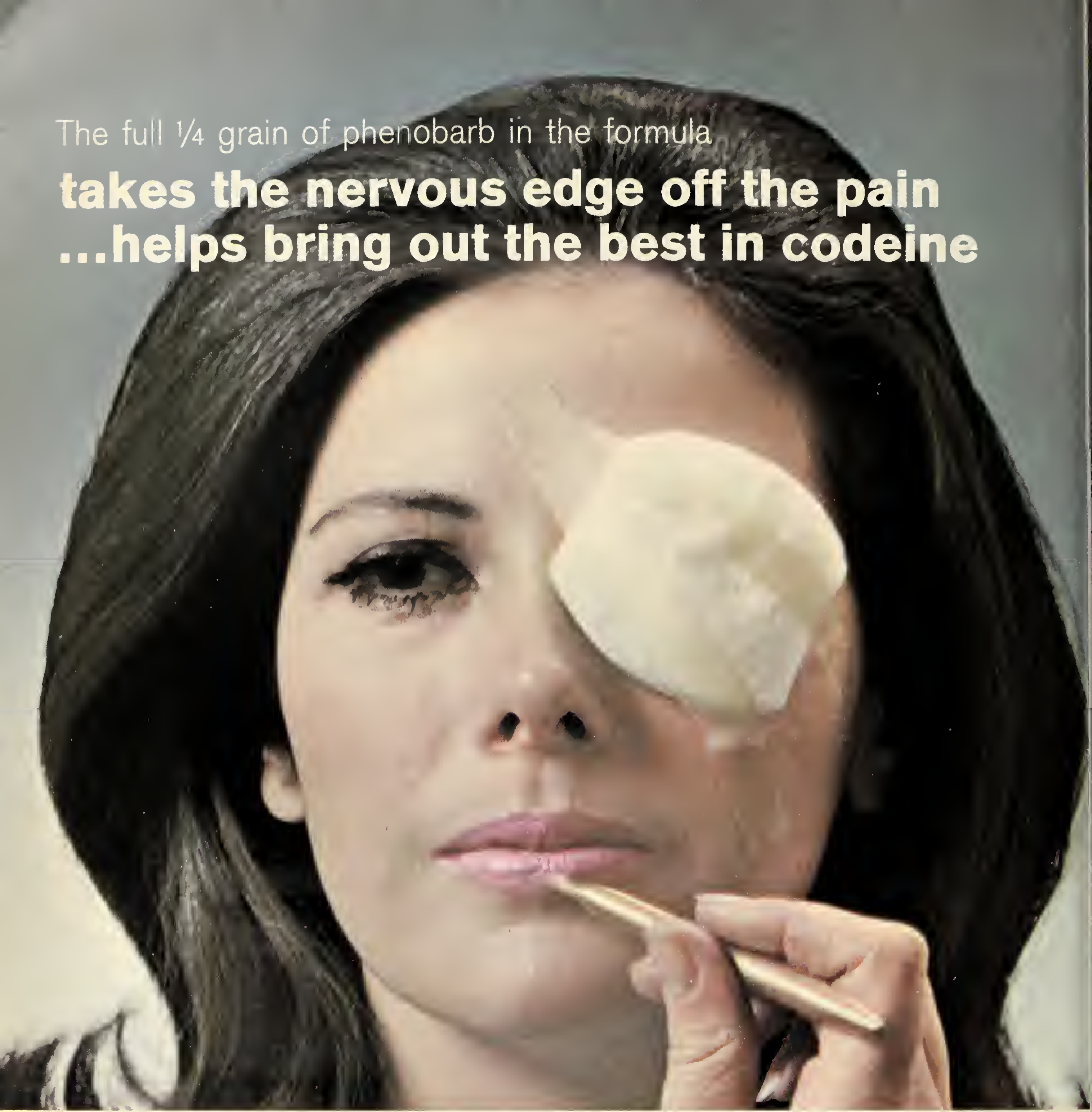
The full ¼ grain of phenobarb in the formula
takes the nervous edge off the pain
...helps bring out the best in codeine

Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.)	16.2 mg.
(Warning: may be habit forming)	
Aspirin (2½ gr.)	162.0 mg.
Phenacetin (3 gr.)	194.0 mg.
Hyoscyamine sulfate	0.031 mg.
Codeine phosphate.............	¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)	

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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book reviews

MONGOLISM (Ciba Foundation Study Group No. 25) Edited by G. E. W. Wolstenholme and R. Porter. 95 pp. Illustrated. Little, Brown and Company, Boston, 1967.

This is an excellent little (95 pages) book resulting from a study group meeting held in England on May 10, 1966. Fortunately, relatively quickly (about one year) this material is available to the interested reader which is one of the purposes of publications supported by the Ciba Foundation. It is also internationally represented by such outstanding authorities as Lord Brain and L. S. Penrose. It is rather interesting that a book with so simple a title as "Mongolism" has so much in depth material. The scientific and genetic implications of what is a human model of chromosomal aberration is presented in detailed formal papers and in innumerable discussions following the papers which I found to be very interesting in appreciating the different views of scientists throughout the world. This symposium will undoubtedly be particularly interesting to the investigator but it also provides a number of observations which clinicians will appreciate in broadening their knowledge regarding a common anomaly which is now more than a clinical curiosity.

Seven formal papers are preceded by a historical introduction by Lord Brain to John Langdon Haydon Down who in 1866 described the mongolian type idiot. A closing section in the General Discussion also surveys the different authoritative opinions regarding the nomenclature best suited for this disorder. Whether an eponym is preferable to "mongolism" or trisomy 21 has many interesting ramifications.

Each paper is presented in adequate detail and is not just a sketchy review article. Matsunga's presentation is based on data from 834 cases of Down's syndrome in Japan. Many of these observations establish a similarity to the pattern seen in caucasians (parental age, etc.). Class A (mongolism independent of maternal age) and class B (age dependent) mongolism are mentioned by several authors who consider as an important etiology in some patients consanguinity associated with recessive genes and maternal viral infections. Dermatoglyphic analysis (G. F. Smith) according to this author is best done on finger-tips rather than toe patterns and may eventually prove (L. S. Penrose) to be a valuable adjunct in separating the trisomy of chromosomes 21 and 22. In another presentation delayed DNA synthesis is discussed from information obtained on cultured skin cells from mongoloids (U. Mittwoch). DNA replication patterns in cultured lymphocytes (M. Fraccaro et al.) from mosaic female mongols were studied using radioautography and the observations suggest some degree of asynchrony between chromosomes 21 and 22 which may eventually aid clinical identification. The granulocyte enzyme activities in trisomy 21 were also reviewed (W. J. Millman et al.) and the many reported changes appear not to be related to specific gene determinants on chromosome 21.

Several alternate possibilities to the many accepted views of the chromosomal defects in mongolism are considered by each author in addition to an interesting general discussion section at the end of the symposium. These alternate possibilities add many intriguing concepts which scientists throughout the world are considering in their work with this entity.

Richard J. Allen, M.D.
Associate Professor
Department of Pediatrics
University of Michigan Medical Center

NEW DRUGS: 1967 edition Evaluated by A.M.A. Council on Drugs, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610, 1967, pp 590, 16 x 24 cm., $3.50.

The physician must have readily available sources of balanced, authoritative information in order to cope effectively with the complexities of modern pharmacotherapy. *New Drugs,* a publication of the A.M.A. Council on Drugs, now in its third edition, provides such information on new drugs.

The 1967 edition of *New Drugs* is a compilation of introductory statements on various therapeutic classes of drugs and monographs on single-entity drugs marketed in the United States during the period 1957-1966. It contains 265 individual drug monographs, each of which gives information on the actions and uses of the drug and its adverse reactions, contraindications or precautions, dosages and routes of administration, and sizes and strengths of available preparations. The introductory statements to 21 chapters have been thoroughly revised and 10 new monographs have been added. These monographs and introductory statements are based on a thorough review and evaluation by the Council on Drugs and its consultants of all the laboratory and clinical information, including unpublished data, available to them. Thus, the book presents a concise, unbiased assessment of the newer drugs within the perspective of the therapeutic application of all of the commonly used agents in a particular class of drugs. Since a monograph on a drug is included whether or not the Council's opinion is favorable, *New Drugs* is in no sense a list of approved or accepted drugs.

The index lists drugs by both their nonproprietary (generic) and trade names and includes therapeutic entries. A list of Canadian trade names equivalents is given in the appendix.

—AMA

HOW TO LIVE WITH AN ALCOHOLIC. By Jorge Valles. 92 pp. $1.00. Essanders Special Edition, New York, 1967.

The 92 pages of this recent slim paperback bring a message of hope and encouragement to the relatives of people with severe drinking problems.

Trying to convey his obviously optimistic viewpoint (the last chapter is entitled "There is always hope for recovery," Dr. Valles tends to oversimplify many of the serious problems, and minimizes the significant personality defects found in some of the more chronic excessive drinkers. (See for instance Zwerling, Israel and Rosenbaum, Milton — "Alcoholic Addiction and Personality," Chapter 31, American Handbook of Psychiatry, Basic Books, 1959, pp 623-644).

On the other hand, questions which relatives often ask, he answers forthrightly, with a refreshing absence of psychiatric jargon. The book may be useful to them as a very elementary primer.

Like many competent physicians who treat alcoholics, Dr. Valles, a dedicated VA psychiatrist, probably knows a great deal more about the problem than is apparent in this pamphlet.

Jose' J. Llinas, M.D.
East Lansing

The book review of *Emotionally Handicapped Children and the Elementary School* in the August issue listed the authors incorrectly. They are Eli Z. Rubin, Ph.D., Clyde Simsom, M.D., and M. D. Betwee.

Did You Know . . .

. . . that reports from Michigan Department of Health statisticians of tuberculosis incidence show how the need continues. The total number of new cases of tuberculosis reported in 1966 was 3,236, up nine percent over the 1965 total of 2,963. Of the total cases reported, 2,425 were active—or communicable tuberculosis requiring immediate treatment—up ten percent over the 1965 total of 2,199.

. . . that deaths in Michigan caused by emphysema increased 400 percent in the last decade. . . .

BOOKS RECEIVED

Developing EGO Functions in Disturbed Children: Occupational Therapy in Milieu. By Lela A. Llorens and Eli Z. Rubin. Wayne State University Press, 1967. 146 pp.

Effects of External Stimuli on Reproduction (Ciba Foundation Study Group No. 26) Edited by G. E. W. Wolstenholme and Maeve O'Connor. 107 pp. Illustrated. Little, Brown and Company, Boston, 1967

Caste and Race: Comparative Approaches (Ciba Foundation Symposium). Edited by Anthony de Reuck and Julie Knight. 348 pp. Illustrated. Little, Brown and Company, Boston, 1967. $12.

Development of the Lung (Ciba Foundation Symposium). Edited by A. V. S. de Reuck and Ruth Porter. 408 pp. Illustrated. Little, Brown and Company, Boston, 1967. $13.00

Endocrinology of the Testis (Ciba Foundation Colloquia on Endocrinology, Vol. 16). Edited by G. E. W. Wolstenholme and Maeve O'Connor. 331 pp. Illustrated. Little, Brown and Company, Boston, 1967. $12.50

Thiamine Deficiency: Biochemical Lesions and their Clinical Significance (Ciba Foundation Study Group No. 28). Edited by G. E. W. Wolstenholme and Maeve O'Connor. 163 pp. Illustrated. Little, Brown and Company, Boston, 1967.

Mongolism (Ciba Foundation Study Group No. 25). Edited by G. E. W. Wolstenholme and R. Porter. 95 pp. Illustrated. Little, Brown and Company, Boston, 1967.

The Neurologic Examination. By Russell N. DeJong. 1168 pp. Illustrated. $29.50. Hoeber Medical Division, Harper & Row, New York, 1967.

Today's Health Guide. Edited by W. W. Bauer, 624 pp. Illustrated. $5.95. American Medical Association, 1965.

Foot Disorders. By Nicholas J. Giannestras. 521 pp. Illustrated. $22.00. Lea & Febiger, Philadelphia, 1967.

A Manual of Clinical Allergy. By John M. Sheldon, Robert G. Lovell, and Kenneth P. Mathews. Second Edition. 550 pp. Illustrated. $15.00. W. B. Saunders Company, 1967.

Principles of Biomolecular Organization. (Ciba Foundation Symposium.) Edited by G. E. W. Wolstenholme and Maeve O'Connor. 491 pp. Illustrated. $15.00. Little, Brown and Company, Boston, 1966.

Radiology in World War II. Edited by Kenneth D. A. Allen. Over 900 pp., illustrated. $8.25. United States Government Printing Office, Division of Public Documents, Washington, D.C., 1967.

Diabetes for Diabetics. By George F. Schmitt. 237 pp., illustrated. $5.95. The Diabetes Press of America, Inc., Miami, Florida, 1965.

in memoriam

Robert S. Breakey, M.D., Dies; Former Councilor

Robert S. Breakey, M.D., retired Lansing urologist, former MSMS Councilor and past president of the North Central Branch of the American Urological Association, died August 17. He was 69.

A native of Ann Arbor, Doctor Breakey received his medical degree from the University of Michigan in 1924 and served his internship and residency at the University Hospital. Later, he was an instructor in urology in the Hospital's Department of Surgery. Doctor Breakey's son is a fourth-generation physician, and Doctor Robert Breakey's grandfather, William F. Breakey, M.D., was an early President of MSMS. All four Doctors Breakey were graduated from the University of Michigan Medical School.

During World War I Doctor Breakey served with Base 17, Harper Hospital Unit, in France.

Active in MSMS affairs, Doctor Breakey served as a delegate from Ingham County to the MSMS House of Delegates for eight years. For five years he served as a MSMS Councilor, and he was a past president of the Ingham County Medical Society.

He was also a past president of the Detroit Urological Society and of the North Central Branch of the American Urological Association.

Memberships included, in addition to the ones named above: the American Neisserian Medical Society; the American Urological Association; life member of the Michigan Union and of the Elks Lodge Number 196; Nu Sigma Nu medical fraternity; local, state, and six national philatelic organizations; and the Lansing U and I Club.

Doctor Breakey had served as vice chief-of-staff and chief of urology at E. W. Sparrow Hospital and chief of urology at St. Lawrence Hospital. He also at one time was affiliated with Community Hospital in Mt. Pleasant.

C. H. Eisman, M.D., Grosse Pte. Pk.

Clarence H. Eisman, M.D., Grosse Pointe Park, Life Member of MSMS, died August 8 at the age of 80.

A native of Detroit, Doctor Eisman was reportedly the first surgeon to practice at Ford Hospital when it opened more than 50 years ago. He attended Alma College and was graduated from the Detroit College of Medicine and Surgery. In 1914 he joined the Ford Motor Car Company and was sent by Henry Ford to New York for postgraduate work prior to returning to Ford Hospital.

After serving in the United States Army during World War I, he returned to Detroit and entered private practice.

A pediatrician, Doctor Eisman was medical coordinator for the Michigan Crippled Children Commission, an incorporator of the Detroit Rehabilitation Institute and medical advisor to the United Cerebral Palsy Association.

He was a member of the Detroit Pediatric Society, which honored him for 50 years of service, Nu Sigma Nu medical fraternity and Ashlar Lodge F & AM.

In addition to his connection with Ford Hospital, Doctor Eisman was affiliated with Childrens and Memorial hospitals in Detroit.

P. P. Galvin, M.D., Detroit

Paul P. Galvin, M.D., Medical Director at Detroit's Carmel Hall Home for the Aged, died July 29. He was 64.

Doctor Galvin had been on the staff of Providence Hospital for the last 40 years, since he came to Detroit in 1926.

Born in Iowa, he was a graduate of Loras College in Dubuque and of the University of Iowa Medical School.

R. C. Norton, M.D., Plymouth

Richard C. Norton, M.D., retired Plymouth physician, died August 11 at the age of 66.

Born in Dalton, Massachusetts, Doctor Norton was graduated from Yale University Medical School in 1925 and served his internship at New Haven Hospital. He did his residency at Barnes Hospital in St. Louis, Missouri.

During World War II Doctor Norton served in the Medical Corps of the United States Army with the rank of lieutenant colonel.

He had served on the National Board of Medical Examiners and he was affiliated with Battle Creek Sanitorium, Harper Hospital in Detroit, and the Veterans Administration Hospital in Detroit.

C. A. Ruedisueli, M.D., Mt. Clemens

Clarence A. Ruedisueli, M.D., Mt. Clemens physician, died August 6 at the age of 65.

A graduate of the Detroit College of Medicine and Surgery, Doctor Ruedisueli practiced in Roseville for 38 years. He was a native of Detroit.

Doctor Ruedisueli was affiliated with St. Joseph's Hospital in Mt. Clemens.

His medical fraternity was Phi Rho Sigma.

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'68 Maternal Welfare Conference Set; Speakers Listed

The program is announced early for the Seventh Annual Michigan Conference on Maternal and Perinatal Welfare on March 26 and 27, 1968, at the Pick-Durant Hotel, Flint.

Chairman for the Conference is Jack W. Thompson, M.D., of Flint.

The Conference will start on Tuesday, March 26, with a 1:30 PM talk on "Intrauterine Pressures," by Richard W. Stander, M.D., Chairman of the Department of Obstetrics-Gynecology, at the University of Cincinnati College of Medicine, Cincinnati. Other talks that afternoon will be "Chronic Fetal Distress," at 2:00 by Robert H. Messer., M.D., Assistant Professor, Department of Obstetrics-Gynecology, from the University of Nebraska College of Medicine in Omaha; "New Abortion Laws," at 3:00 by E. Stewart Taylor, M.D., from the Department of Obstetrics-Gynecology at the University of Colorado Medical Center in Denver; and "Infertility," at 3:30 by Herbert W. Horne, Jr., M.D., Fertility-Gynecology, Brookline, Massachusetts.

The Tuesday evening banquet speaker will be Willis E. Brown, M.D., from the University of Arkansas Medical School.

On Wednesday, March 27, talks will begin at 9:00 AM with "Neonatal Environmental Control," by Marshall Klaus, M.D., from the Department of Pediatrics at Western Reserve University School of Medicine in Cleveland; at 9:30 "Hypoglycemia—A Treatable Cause of Brain Damage," will be discussed by Marvin Cornblath, M.D., Professor of Pediatrics at the University of Illinois College of Medicine in Chicago; and at 10:30 the "Use of Rh Immunoglobulin in Hemolytic Disease of the Newborn," will be discussed by John G. Gorman, M.D., Director of the Blood Bank at the Presbyterian Hospital in New York City.

The conference will adjourn at 12:00 noon.

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Oct. 4-5 – American Cancer Society, Michigan Division, Annual Convention, Jack Tar Hotel, Lansing

Oct. 4-6 – Michigan Tuberculosis and Respiratory Disease Association, Annual Meeting, Pantlind Hotel, Grand Rapids

Oct. 5 – Michigan Thoracic Society, Annual Meeting, Pantlind Hotel, Grand Rapids

Oct. 5-7 – Medical School Alumni Reunion, University of Michigan Medical School, Ann Arbor

Oct. 9-13 – International Conference on Leukemia and Lymphoma, University of Michigan Medical School, Ann Arbor

Michigan Nurses Association, Annual Convention, Jack Tar Hotel and Civic Center, Lansing

Oct. 15-21 – National Community Health Week

Oct. 27-28 – Regional Meeting, American College of Physicians, University of Michigan Medical School, Ann Arbor

Nov. 2 – Southwestern Michigan Clinic Day

Nov. 8 – The Council, MSMS Headquarters, East Lansing

Nov. 15-17 – International Conference on Fertility and Family Planning—A World View, University of Michigan Medical School, Ann Arbor

Nov. 26-29 – AMA Clinical Convention, Houston

Nov. 26-29 – Conference on Genetics in Medicine, sponsored by the American College of Physicians, University of Michigan Medical School, Ann Arbor

Dec. 4-5—Institute for Guidance Councilors, Michigan Education Association Conference Center, St. Mary's Lake, Battle Creek

Dec. 6-7 – 15th Annual Symposium on Trauma, Wayne County Medical Society Headquarters, Detroit

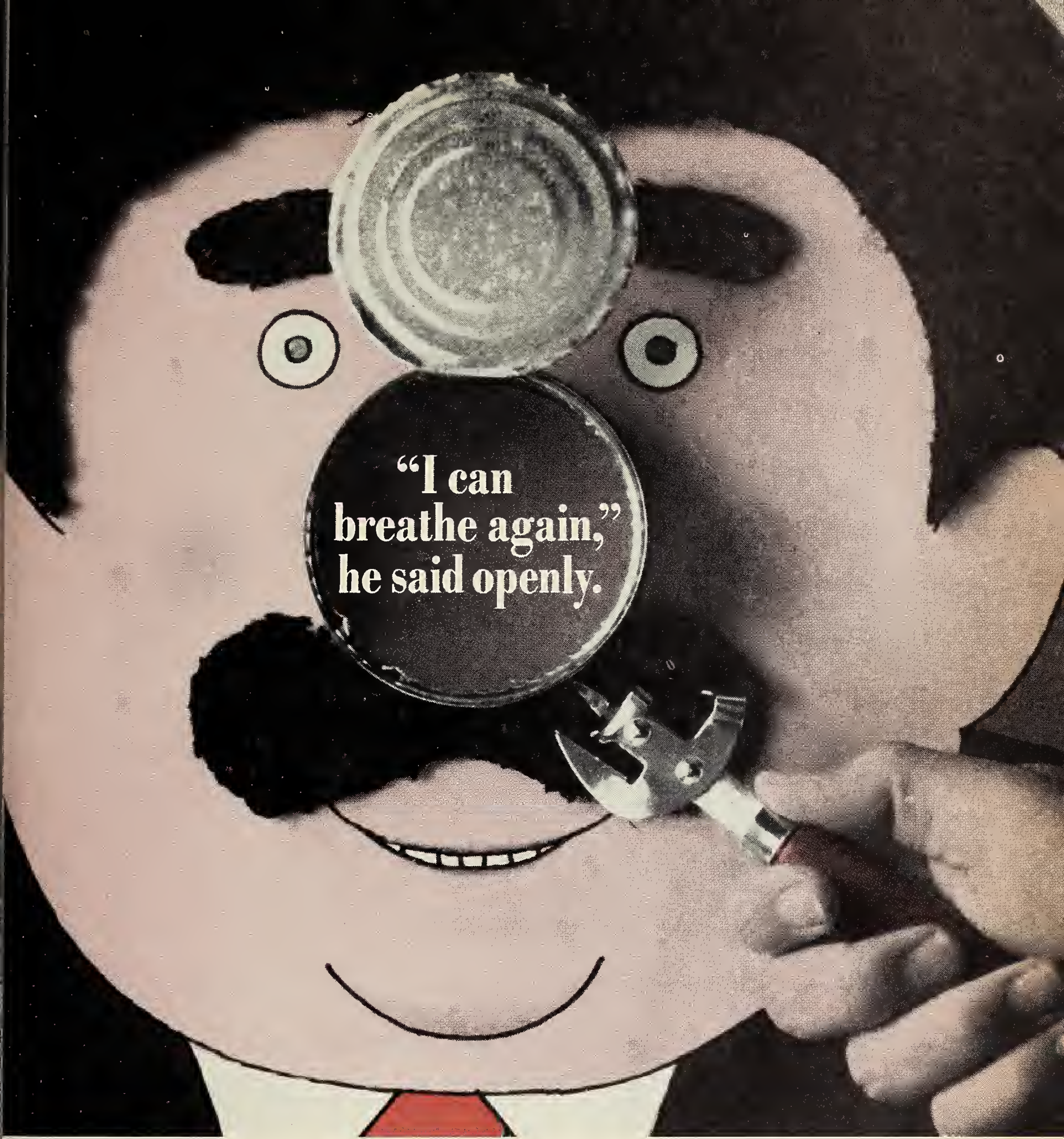
Dec. 6-7 – Conference for Head Nurses, Kellogg Center, East Lansing

Dec. 13 – The Council, MSMS Headquarters, East Lansing

March 26-27 – Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 23-28 – Student American Medical Association, Detroit

May 1-8 – Mental Health Week



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Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A

Geigy

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Under license from
Boehringer Ingelheim G.m.b.H.

even in ulcerative colitis...

characterized by:
- diarrhea, cramps, tenesmus
- bloody, mucoid, purulent stools

LOMOTIL® tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . .	½ tsp.* t.i.d. (3 mg.)
6-12 mo. .	½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .	½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .	1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .	1 tsp. q.i.d. (8 mg.)
8-12 yr. . .	1 tsp. 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

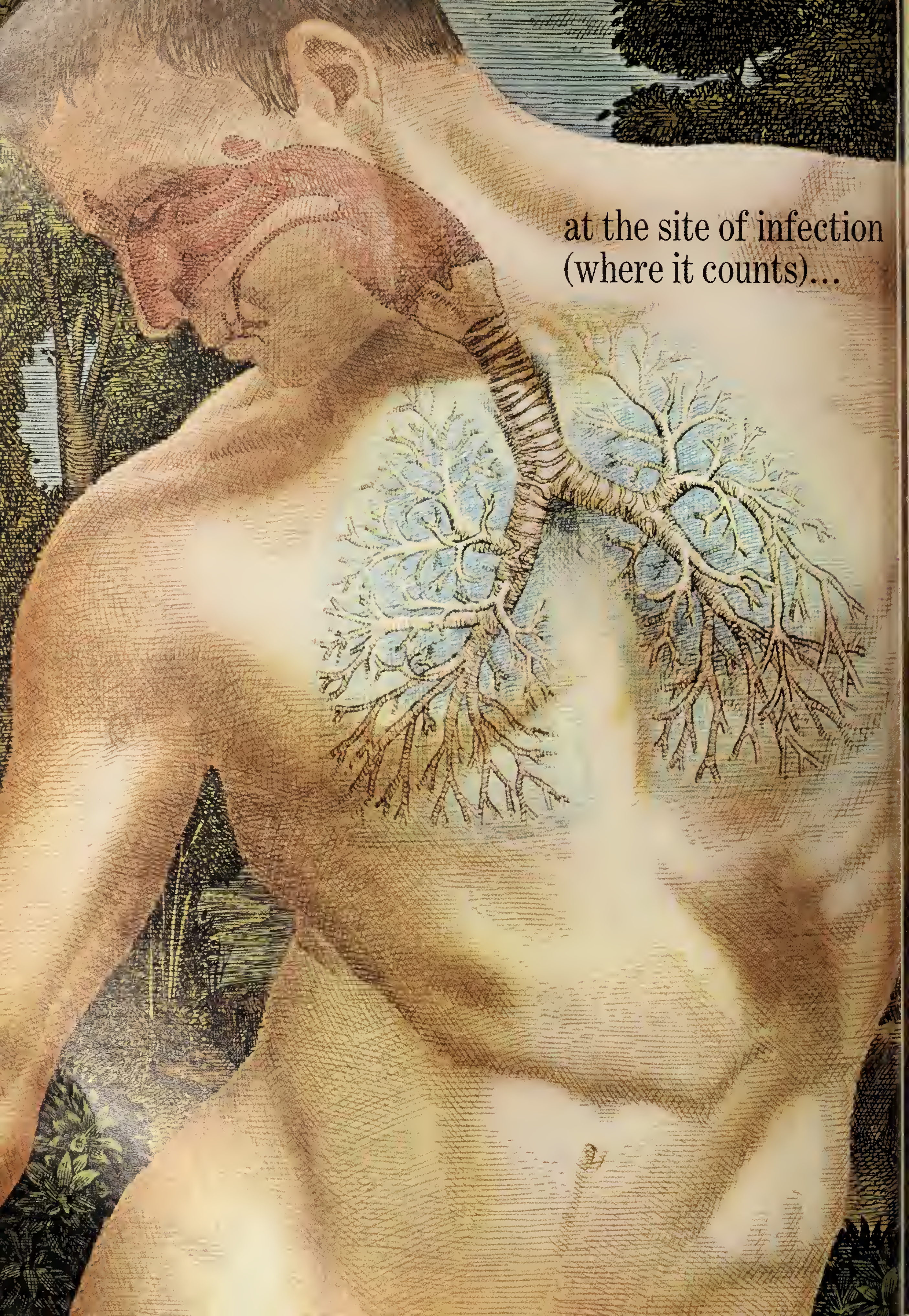
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180:*1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appear
be definitely related to use of the drug, laboratory findings
characterized by increased direct-reacting bilirubin, ele
alkaline phosphatase levels, negative or weakly positive cep
flocculation and thymol turbidity tests, elevated serum glu
oxalacetic transaminase levels, peripheral eosinophilia, and
mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha
been reported in other patients taking prolonged courses
medication. Patients with chronic infection have been give
to 2 Gm. of the drug daily for periods of two to six months
patients with rheumatic fever have taken prophylactic do
0.5 Gm. daily for two years without difficulty. In one gro
144 patients who received the drug daily for two years, no
dice was noted. It was of interest that members of six of
patients' families, who were not taking the drug, had epi
of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels
determined in a group of fifty-four adults and children wh
250 mg. of Ilosone daily for an average of sixteen mont
rheumatic fever prophylaxis. The results were compared
those of a similar group of forty-four patients who received
icillin. There were no cases of jaundice in either group. Elev
of SGPT and serum alkaline phosphatase levels during the
of treatment was observed in one patient treated with Il
and in two patients treated with penicillin. Seven other pa
in the group receiving Ilosone and four others in the peni
group showed elevations in one of the tests at some time d
administration of the drugs.

Very satisfactory therapeutic results, without toxicity,
reported in 102 pediatric patients who received short-term
day) courses of Ilosone in the treatment of streptococcus
tions. Results of liver function tests in these patients
comparable to those in a similar control group who had rec
penicillin.

Gastro-intestinal disturbances not associated with hepat
fects are observed in a small proportion of individuals as a
of a local stimulating effect of the medication on the alime
tract; however, the normal intestinal gram-negative bac
flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with th
of erythromycin, there have been occasional reports of urti
skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for
Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of
weight, the usual dosage is 5 mg. per pound every six hour
children twenty-five to fifty pounds, 125 mg. every six
(Tablets Ilosone Chewable should be chewed or crushed
swallowed with water.)

For adults and for children over fifty pounds, the usual d
of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythro
therapy should be considered.

In the treatment of syphilis, the recommended total dos
20 to 30 Gm. given in divided doses for a period of ten to f
days. Close follow-up of the patient is necessary since ery
mycin drugs have not had adequate evaluation in all stag
syphilis. Examinations of spinal fluid are recommended as
of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four day
recommended. In the treatment of gonorrhea, patients w
suspected lesion of syphilis should have a dark-field examin
before receiving antibiotics, and monthly serologic tests s
be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 25
(equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equiv
to base) per 5-cc. teaspoonful, in 60-cc. and pint-size pack

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiv
to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pack

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc
packages, with dropper calibrated at 25 and 50 mg.

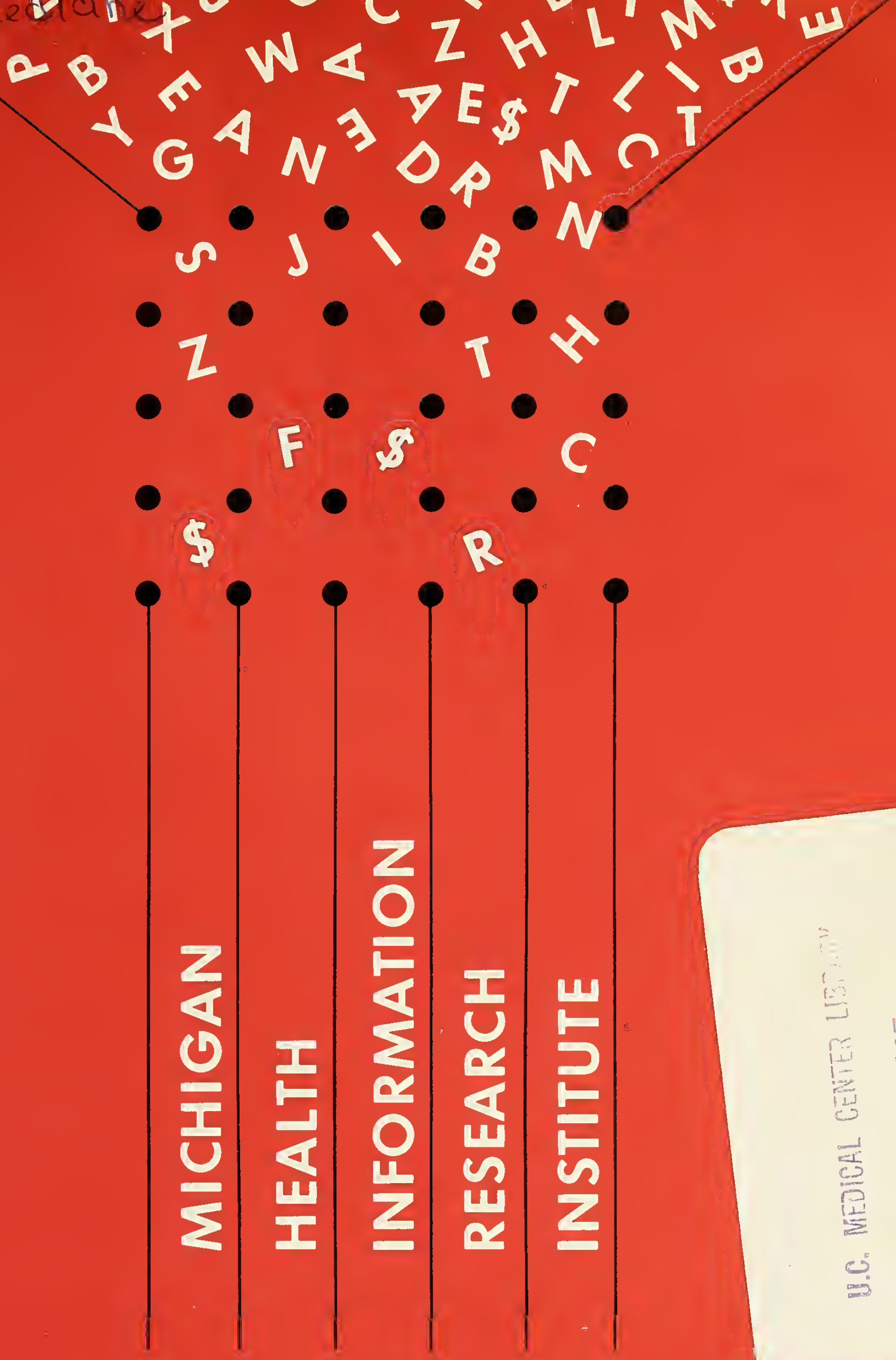
Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to
in bottles of 50. [0

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

ichigan Medicine

MICHIGAN STATE MEDICAL SOCIETY VOLUME 66, NUMBER 21 NOVEMBER 1967



MICHIGAN HEALTH INFORMATION RESEARCH INSTITUTE

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Five Original Scientific Articles

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Concerns Expressed about How Quackery Delays Proper Care

And Others re Education, Socio Economics, Ancillary

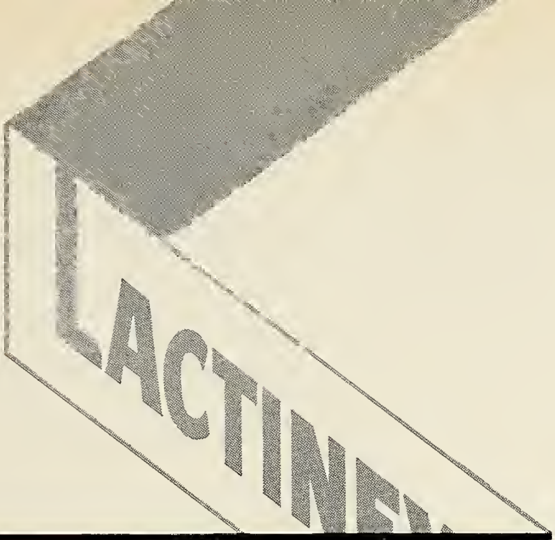
Dilantin®
(diphenylhydantoin)
PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67



LACTINEX®

TABLETS & GRANULES

- **to help restore and stabilize the intestinal flora**
- **for fever blisters and canker sores of herpetic origin**

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,[1, 2, 3, 4] LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5, 6, 7, 8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

HYNSON, WESTCOTT
& DUNNING, INC.
HW&D BALTIMORE, MARYLAND 21201

(LX04)

LX
LX
LX

Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.
(initial adult dose)

NegGram

Brand of

nalidixic aci

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults**, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children**, available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

---

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

MICHIGAN MEDICINE

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1409 Gynecology Clinical Conference: Pelvic Exenteration/George W. Morley, M.D.; S. Martin Lindenauer, M.D.; Joseph C. Cerny, M.D.
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1419 Vascular Causes of Death in Pregnancy/R. H. Nishiyama, M.D., D. G. Anderson, M.D.; G. L. Brody, M.D.; T. R. Meadows, M.D.; A. J. French, M.D.
1424 The Carpal Tunnel Syndrome/Kenneth R. Magee, M.D.; Edgar A. Kahn, M.D.
1429 A New Antipyretic Agent/Charles F. Weiss, M.D.; Scott T. Harris, M.D.

SPECIAL ARTICLES

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Volume 66, Number 21

The cover design this month is an attempt to symbolically describe the new Michigan Health Information Research Institute. The Institute, authorized by the recent MSMS House of Delegates, is described in a comprehensive article beginning on Page 1439.

Published Semi-Monthly, Trimonthly in December and February; 26 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at Lansing, Michigan. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Classified advertising should be sent directly to the Michigan State Medical Society. General display advertising representatives, Les Strang Advertising, Inc., 2082 S. State Road, Ann Arbor, Michigan; Phone: Area Code 517, 663-3346. © 1967 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

president's message

AVAILABILITY COMPETENCE PERSONALIZATION

"Where are we going?"

"Where should we be going?"

Those were two question I raised in my address to the recent MSMS House of Delegates.

Yes, I know we want to continue to provide the best possible care for all the people—but what are some of the special aspects of this goal today?

Three words must be considered:

—Availability

—Competence

—Personalization

In discussing these words with the delegates, I declared that: **Availability** is a relative term. The present general excellence of our peoples' health in the State of Michigan attests to competence at this time. But is this enough?

There is an insistent demand for more health services, more physicians, more health personnel of all types, and more facilities for prevention, diagnosis, treatment, and rehabilitation. MSMS is in accord with all these demands for service.

As we look ahead at medical care and research, the future must be constructed with the energy and daring that have built other aspects of our national economy. The dimensions of American medicine are deepening and widening, and we are relying more and more on various other fields of science, engineering, and technology for help in developing the equipment and techniques needed. As this scientific and technical process continues, we also have the complex task of making the benefits of new knowledge and skills as they apply to medicine readily available to every member of society as rapidly as possible. It becomes the personal responsibility of each of us to involve ourselves in these programs and thus assure our individual availability.

Competence may be viewed individually and collectively. Expansion of our efforts in the social and economic aspects of health care is fully as important and urgent as exploration into the mysteries of the cell or outer space. Whether we are thinking in terms of science or society, American medicine has never faced a greater array of challenges and problems than those that confront us today. If we are to cope with the existing and anticipated problems in the health care field, the medical profession must be prepared to seize the initiative and keep it. The one big, all-encompassing challenge is to do better—to become more competent.

Personalization in our care is essential. We must be certain that every patient senses constantly our warm, personal interest in him and all that affects his environment.

These three words have a bearing on the questions about where we are going.

Many opportunities and problems face medicine and MSMS.

Within our State Medical Society I firmly believe that task forces directed toward accomplishing specific objectives should be developed. These groups would cut across the work of many of our committees and by coordinating their work, permit us, as a profession, to make our contributions more effective. Certainly such task forces plus greater access to research findings can enhance our present programs.

In conclusion, by improving our availability, our competence, and our personalization, we can fortify ourselves in meeting our grave responsibilities.

B. M. HARRIS, M.D.

DOCTOR,

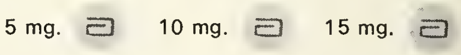
Here is the expanded Abbott anorectic program designed to meet the individual needs of your overweight patients.

ABBOTT

THE PRODUCT

DESOXYN® Gradumet®

METHAMPHETAMINE HYDROCHLORIDE IN LONG-RELEASE DOSE FORM



DESBUTAL® 10 Gradumet

10 mg. METHAMPHETAMINE HYDROCHLORIDE, 60 mg. SODIUM PENTOBARBITAL

DESBUTAL 15 Gradumet

15 mg. METHAMPHETAMINE HYDROCHLORIDE, 90 mg. SODIUM PENTOBARBITAL

MOOD ELEVATION

DESOXYN Gradumet

Smooth appetite control plus mood elevation

Typically, the obese patient is a repeat dieter. And with each failure, the task looks more hopeless. Therefore, it is often just as important to lift the mood as to curb the appetite. Desoxyn Gradumet does just that. It gently elevates and sustains the mood. And no other product—amphetamine or non-amphetamine—is more effective in suppressing appetite.

DESBUTAL Gradumet

For patients who can't take plain amphetamine

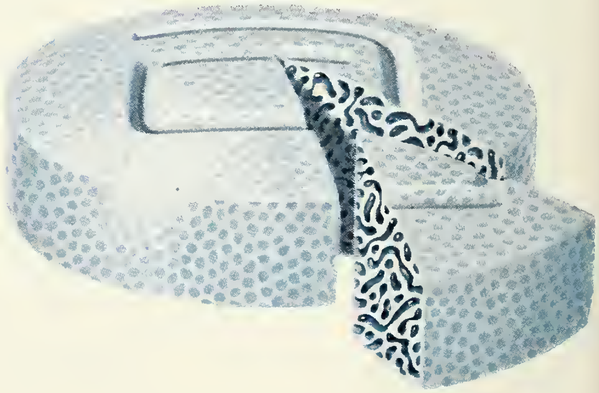
Desbutal Gradumet contains 2 drugs, each in its own tablet section, combined back to back to form a single tablet. One section contains Desoxyn to suppress the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to soothe the patient and counteract any excessive stimulation. The drugs are released in an effective dosage ratio throughout the day.

CONTROLLED-RELEASE

HOW IT DIFFERS FROM LONG-RELEASE

The Gradumet is made up of thousands of interconnecting channels, much like a sponge. These channels—filled with a drug—end at the outer surface of the tablet. When fluid comes in contact with the Gradumet, the drug in the outer ends of the channels dissolves. As the fluid makes its way up the channels, there is a continuous release of medication.

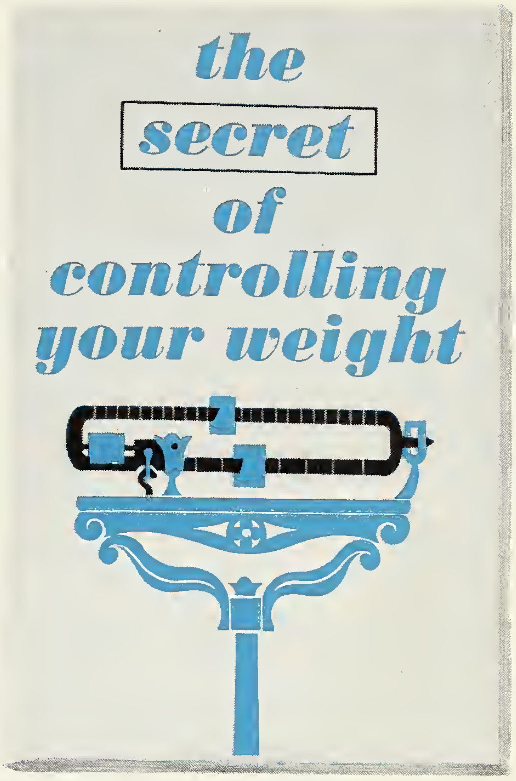
Since the rate of release is rigidly determined by the size and number of channels, the Gradumet is able to provide controlled-release as well as long-release. Patients get a measured amount of medication, moment by moment, throughout the day—from a single oral dose.



THIS IS A RELEASE YOU CAN COUNT ON

THE PROGRAM

WEIGHT CONTROL BOOKLET



To help your obese patients understand why they are overweight—and what they can do about it—Abbott has a booklet called "The Secret of Controlling Your Weight." *It is available to your patients only through you.*

Here is a partial list of the topics covered:

Why you are overweight
Rewards of weight reducing
Balanced meals
Helpful hints
Hunger between meals
Snacks
Weekly weighings
Exercise
Holidays, vacations, special events
Leanness and longevity

Each topic is covered on one page in simple and easy-to-understand language. At the back of the booklet, there is a list of 160 foods showing their caloric content.

FOOD DIARY

The Food Diary is designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing everything down that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

This booklet also lists the caloric content of 160 foods.

See Brief Summary on next page.

THE PRICE

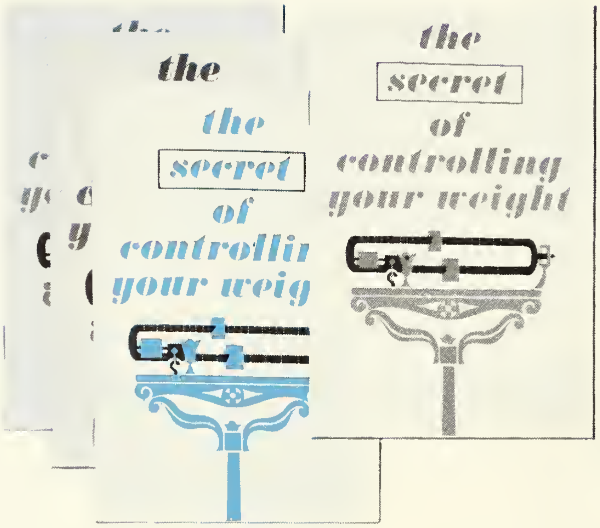
ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Desoxyn Gradumet and Desbutal Gradumet are so reasonably priced that patients in many cases save enough (compared to other leading long-release anoretics) to get five weeks of medication for the price of four.

FREE SUPPLIES



There are four weight control booklets, each with the same text, but with a different sample in the back of the booklet to meet your individual patient's needs. You have your choice of Desoxyn Gradumet in 10 mg. or 15 mg. strengths as well as Desbutal 10 Gradumet and Desbutal 15 Gradumet. The Food Diary is the same for all of the weight control booklets.

Your Abbott man will be happy to supply you with booklets. Just ask him.

CONTRAINDICATIONS: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

PRECAUTIONS, SIDE EFFECTS: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and addiction.

Amphetamine side effects such as a headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is usually transient.

701069

Gradumet—Long-release dose form, Abbott: U.S. Pat. No. 2,987,445.

viewpoints

The Dangers of Adeno-Tonsillectomy

BY GEORGE H. LOWREY, M.D.
SCIENTIFIC EDITOR

The most common surgical procedure perormed in the United States is an adeno-tonsillecomy. It is estimated in the United States during 964 that 1.2 million persons underwent this proedure of which 101 are known to have died beause of it.

According to British authorities, one out of very six children subjected to adeno-tonsillectomy oses nearly 10 percent of his blood volume. (*Briish Medical Journal* Vol. 2, p. 1349, 1965). The majority of deaths are caused by excessive blood oss and it is pointed out that "bleeding" and "clotting" times are very ineffectual indicators of bleeding problems. With our present methods for measuring clotting mechanisms such crude guides hould no longer be used if there is the least suspicion of a true bleeding tendency.

Adenoidectomy and tonsillectomy are performed most frequently between the ages of five and eight ears. The usual reason indicated for these proedures are that the tonsils are "enlarged" or the hild has been subject to very frequent respiratory ract infections. The size of tonsils in a child of ix years are often very deceiving. Relatively peaking, the tonsils may have attained some 90 o 100% of their usual adult size but they are ound in an oral pharynx which has attained only 0 to 50% of its adult size. This relative size of he tonsil is true regardless of the number of inections that the child has experienced.

It should also be emphasized that the frequency of respiratory tract infections reaches a peak beween five and six years. If then the tonsils are emoved at this fortuitous time, invariably there will follow a descending curve of the frequency of olds, sore throats and pneumonia. Every valid tudy that has been carried out in this country or England to show the value of tonsillectomy in reducing the frequency of infections has failed to upport any such relationship.

The only valid criteria for adeno-tonsillectomy re documented recurrent ear infections with increasing hearing loss or peritonsillar abscess.

Following graduation from medical school, I held the hope that with increasing knowledge and education the number of needless tonsillectomies would probably decrease. From my contacts with succeeding generations of children and young adults from high school to college and graduate schools, I am quite convinced that at least in the state of Michigan there is almost no reduction in the frequency with which this surgical procedure is performed. It is hard to believe that some 60 to 70% of our population would have been deaf or that they did have peritonsillar abscesses. Yet this is my estimate of the number of people who have been subjected to this procedure.

The easiest way to prevent deaths due to adeno-tonsillectomy is to avoid this surgery.

When surgery is indicated by the criteria stated, very careful evaluation of each child or adult should be made. It should never be considered a routine procedure. Careful control of bleeding during surgery and close post-operative observation by properly trained personnel are absolute musts.

Stricter standards of deciding the necessity of the procedure must be observed. No longer can we look benignly at the newspaper picture of an entire family of children who are going to the hospital for removal of the tonsils. No longer can we be complacent about the tonsillectomy being a routine procedure before starting school. Less unnecessary surgery combined with better care can improve the statistics and we, as physicians, must see that they are improved.

Well Said, Well Said!

BY MILTON R. WEED, M.D., CHAIRMAN,
MSMS EDUCATION LIAISON COMMITTEE

Well, said, *Detroit News!*

Officials of the Michigan State Medical Society and the three Michigan medical schools often have argued that adequate funds should be appropriated in Michigan to graduate more doctors of medicine as one of the ways to help reduce health care costs.

This point was stressed at the 1967 Medical News Reporting Conference sponsored by MSMS for Michigan reporters from press, radio and television.

The *Detroit News* carried an effective editorial on September 26 that presents this approach for the public and legislators to consider. Following is the complete editorial, which appeared under the heading "Preventive Medicine Needed:"

That $100 medical bill you paid in 1957 would cost more than $136 today and, in all probability, even more next year. Since people can't schedule illness to beat rising prices, the spiral of medical costs affects all of us. Somehow, that spiral must be controlled.

The medical cost question has many different aspects: Hospital charges have led the price increase parade, advancing about 17 percent last year. Physicians' fees were up almost 8 percent. Only prescriptions and drugs have had falling or steady prices since 1957.

But, while each "unit" of medical care costs more, people have also been buying more units. The typical consumer is buying about 60 percent more medical service today than in 1950.

This cost explosion doesn't always "hit home." More than 80 percent of the civilian population is covered by private health insurance; people pay for higher prices through higher premiums, but the impact seems less direct. Medicare and Medicaid programs are footing the bill for millions of older people and for families designated as "medically indigent." All citizens pay these bills through higher taxes but, again, the direct impact is hidden.

If Americans are to continue to buy top quality medical care and to provide such care for those with limited income, prices must be kept within bounds. There is a limit to what people can pay in either insurance premiums or taxes.

Two avenues of cost reduction look promising: increased numbers and more efficient use of medical personnel and more extensive use of cost-cutting hospital procedures.

* * *

The government is spending over $4 billion a year to pay medical bills under its various programs. Yet, because of the shortage of doctors and medical technicians and the inefficiencies of many hospitals, that money too often buys nothing but higher prices.

As happens in so many cases, the politicians' answer to medical care is to pay the bill with a great deal of tax money rather than use fewer tax dollars to underwrite the cost of medical schooling or the improvement of hospital administration.

Before the average citizen gets sick just looking at his insurance premium or his tax bill, the government should practice some "preventive medimine" and get at the root causes of medical care inflation.

Continued on 1398

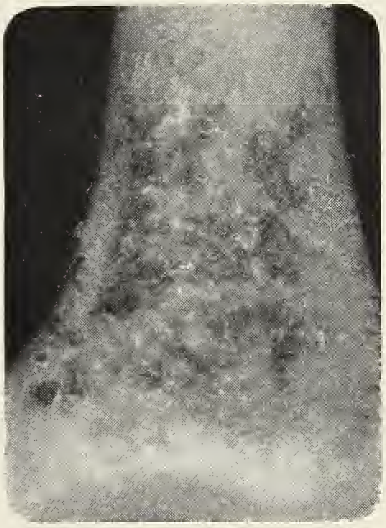
Diarrhea
TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

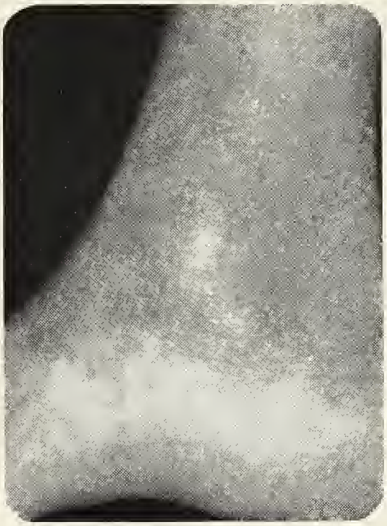
The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Eczema of many years... controlled in two weeks


Before treatment


After treatment—
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
Also available in foam form.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-6

Tell 'em the Truth

BY BROOKER L. MASTERS, M.D., CHAIRMAN, MSMS PUBLICATION COMMITTEE

What do you tell your patient, your legislator, your neighbor when he tosses that old charge at you that "The medical profession doesn't want any more doctors?"

Every doctor should have the facts on his tongue to answer quickly.

The facts themselves provide the answer to the charges that "the AMA limits the enrollment of medical schools" or "the doctors deny that we need more physicians."

Remember these facts and be proud.

First, the AMA-ERF loan guarantee program has, since 1952, made possible 35,000 loans totaling forty million dollars.

Second, AMA members individually, in the past ten years, have donated fifty million dollars to medical schools.

Third, the AMA has actively participated in the development of eleven new medical schools since 1947. By 1972, there will be fifteen more.

Fourth, from 1950 to 1965, the number of physicians has increased from 200,000 to approximately 300,000, an increase of about 50%. The population increased in the same time, about 28%.

These national figures recently were cited in this context at a national conference by John H. Budd, M.D., of Cleveland.

And MSMS members can cite many additional Michigan facts.

1. MSMS long has supported the need to increase the medical schools at Wayne State University and the University of Michigan.

2. MSMS again in September asked the legislature and Governor to appropriate the necessary funds to expand the College of Human Medicine at Michigan State University from its present two-year school to a full medical college.

3. MSMS worked to establish the Michigan Health Council and appropriates annual grants to support its career recruitment efforts, MD Placement Service, etc.

4. MSMS provides both financial and staff help to send the Michigan Health Careers Mobile across the state.

5. MSMS has just ordered its second supply of the AMA *Horizons Unlimited* Careers handbook, with a special Michigan insert.

6. MSMS and the Michigan Health Council, with the cooperation of the Michigan Outdoor Advertising Industry soon will have 100 billboar
across the state recruiting members for the Heal
Team.

7. MSMS has many committees active in t
medical careers field — the Education Liais
Committee, the Committee on Rural Health, t
Committee on Public Relations, and others.

Doctor, stand up and fire back a reply wh
the next person parrots that old charge that t
medical profession doesn't really want more do
tors.

It's so far from the truth.

PR Ideas Wanted

BY BROCK E. BRUSH, M.D., CHAIRMAN, MSMS COMMITTEE ON PUBLIC RELATIONS

The recent AMA Communications Institu
raised some provocative questions. How would y
answer them?

1. When the AMA is attacked in your loc
press, do you or your members take exceptic
and take action or do you simply wait
see what develops?
2. Can the individual member quickly co
municate to the county, the state and t
AMA satisfactorily — and does the rever
process work well? What improvemen
would you suggest re both the up and dow
flow of communications?
3. What systems would you suggest be dev
oped, that are not generally used now,
better communicate with the public?

Those were only three of the questions pos
by the AMA staff at the Institute workshops.

The answers are not easy.

But each of the three questions causes t
physician to do some soul searching.

It is not enough to be critical.

Positive, specific suggestions to improve co
munications with the public are needed. Ideas a
wanted. Volunteer helpers are sought.

The MSMS Committee on Public Relatio
uses many of the popular methods of communic
tion — news releases, radio programs, TV ne
clips, speakers bureaus, movies, brochures, etc.

The Committee invites you to read its annu
report in upcoming Proceedings of the 1967 Hou
of Delegates. The Committee report and the add
tional public relations comments under The Cou
cil Annual Report are extensive — and impressiv

The 1967 House of Delegates reference comm
tee which studied the Annual Report of the Co
mittee on Public Relations stated for the record
"The Reference Committee wishes to complime

he Committee on its various efforts, particularly ie Health Careers Mobile, the Health Careers ooklets, and other educational thrusts. We comiend the effort put into the 1967 Annual Conrence on Medical News Reporting and the Comiunity Health Week. The liaison work was espeially commendable, as was the distribution of lected motion pictures to service clubs, etc. We specially compliment the staff members of MSMS r their continuing excellent work." The House ncurred with the Reference Committee comiendations.

Certainly improvements are possible. Already the ommittee on Public Relations has obtained aproval from The MSMS Council to utilize billoards for the first time to help us in recruiting iore health-team members, and to sponsor a series f Quackery Conferences across the state this ming year for the first time.

The MSMS Committee on Public Relations ould be pleased to hear from any members who ish to offer ideas and suggestions on ways to imrove communications with the public. Please send ur ideas to the Committee on Public Relations, Iichigan State Medical Society, 120 West Saginaw, ast Lansing 48823.

ongressman Rates etters as Important

How important are letters to Congressmen?

This question is asked often.

A recent weekly "Washington Report" from the ffice of Congressman Marvin L. Esch, Second Disict of Michigan, focused sharply on the importnce of such personal letters.

"Under present circumstances, letters from conituents are more important than ever before. Vith the myriad of issues facing this Congress, a tter from home that sheds some light on these omplex issues is particularly welcome.

"Of the mail now received, one third could be lassified as issue mail, another third is part of a ontinuing dialogue with federal and local officials n government projects and programs; and the reiainder is what we call "casework." In this latter ategory citizens are helped in their dealings with ederal government services.

"Perhaps this reluctance to communicate is ased on a feeling that letters will receive supercial treatment from this end. Actually, Congressien take great care to read their mail and peronally sign the replies. And I can also state withut hesitation that on several occasions I have een greatly influenced by a well-developed and ctually persuasive letter."

HEW MANEUVER FAILS

BY ROBERT J. MASON, M.D., CHAIRMAN, THE MSMS COUNCIL

It is no wonder that Michigan physicians — and their colleagues across the nation — watch the federal government with an apprehensive eye as it moves more and more into medical care.

The official proceedings in the Congressional Record describe one of the attempts by the Department of Health, Education, and Welfare to change materially a federal program in a devious manner.

Thanks to an amendment by Representative A. W. Watson, Republican of South Carolina, the HEW efforts to circumvent the state planning agency in the administration of federal funds under the Comprehensive Health Planning law were stopped.

HEW had attempted to gain approval to authorize grants without state approval. Some other amendments did pass the House and now are under study in the Senate.

In Michigan the Governor has approved a committee to study the possible formation of such a planning group to implement P.L. 89-749, the Comprehensive Health Planning and Public Health Service Amendments of 1966 (now known as the Partnership for Health Amendments).

Let us examine the Congressional Record and testimony by Congressman Watson about the HEW attempt to make a serious substantive change without calling attention to it during the hearing of the House Committee. The following is excerpted, in consecutive sequence, from the Congressional Record, September 20:

Mr. Watson. Mr. Chairman, when the comprehensive health bill was passed last year it provided, as does the bill before us today, for project grants for health services development. There were three types of these project grants as follows:

First. Services to meet health needs of limited geographic scope or of specialized regional significance.

Second. Stimulus and support for an initial period for new programs of health services.

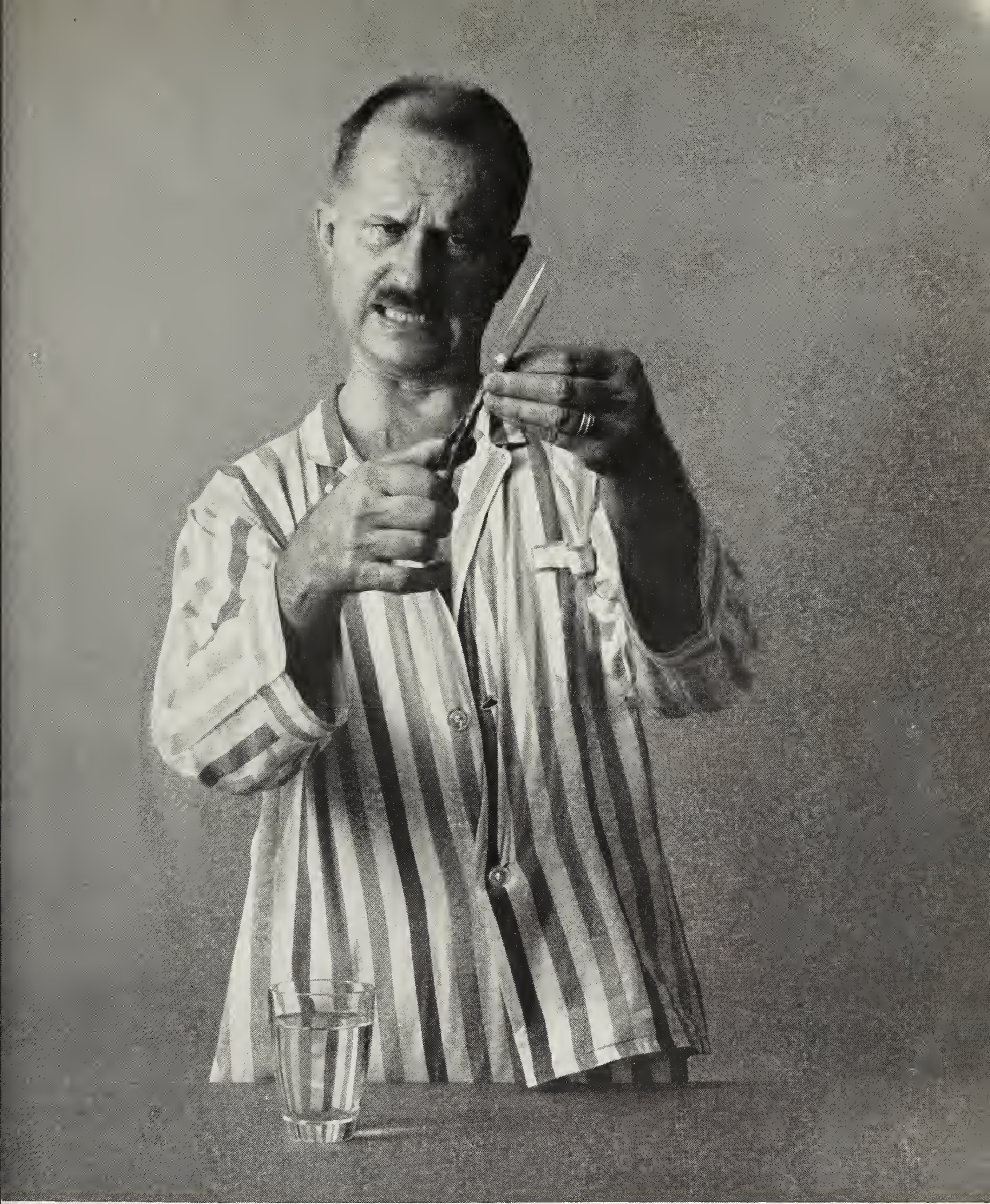
Third. Studies, demonstrations, or training designed to develop new methods.

Projects included in the first and second items could be funded only if consistent with the State plans where they were to take place.

The bill before you now was changed by the drafters without notice or comment. In fact, the

Continued on 1407

Maybe you don't want
your patients to halve Hygroton®chlorthalidone.



aybe your patients complain:
hy don't they make a tablet I don't have to halve?”

ase see brief prescribing summary at the end of advertisement.

Maybe you abandoned Hygroton chlorthalidone because there wasn't a convenient half strength.

tions: Hypertension and many types of
involving retention of salt and water.

indications: Hypersensitivity and most
of severe renal or hepatic disease.

ng: With the administration of enteric-
potassium supplements, which should
d only when adequate dietary supple-
tion is not practical, the possibility of
bowel lesions (obstruction, hemor-
and perforation) should be kept in
Surgery for these lesions has fre-
y been required and deaths have oc-
. Discontinue enteric-coated potas-
upplements immediately if abdominal
istention, nausea, vomiting, or gastro-
nal bleeding occur.

ith caution in pregnant patients, since
ug may cross the placental barrier and
e reactions which may occur in the
thrombocytopenia, hyperbilirubinemia,
carbohydrate metabolism, etc.) are
ial problems in the newborn.

utions: Antihypertensive therapy with
ton should always be initiated cau-
in postsympathectomy patients and
ents receiving ganglionic blocking
or other potent antihypertensive drugs,
are. Reduce dosage of concomitant
pertensive agents by at least one-half.
urates, narcotics or alcohol may po-
te hypotension. Because of the possi-
f progression of renal damage, peri-
etermination of the BUN is indicated.
ntinue if the BUN rises or liver dysfunc-
aggravated. Hepatic coma may be
itated.

olyte imbalance, sodium and/or potas-
epletion may occur. If potassium deple-
hould occur during therapy, Hygroton
be discontinued and potassium sup-
nts given, provided the patient does
ve marked oliguria.

pecial care in cirrhosis or severe
nic heart disease and in patients re-
g corticosteroids, ACTH, or digitalis.
striction is not recommended.

se Reactions: Nausea, gastric irritation,
ing, anorexia, constipation and cramp-
izziness, weakness, restlessness, hy-
cemia, hyperuricemia, headache, mus-
amps, orthostatic hypotension, aplastic
a, leukopenia, thrombocytopenia,
ulocytosis, impotence, dysuria, transient
ia, skin rashes, urticaria, purpura, nec-
g angiitis, acute gout, and pancreatitis
epigastric pain or unexplained G.I.
oms develop after prolonged adminis-
n. Other reactions reported with this
of compounds include: jaundice, xan-
ia, paresthesia, and photosensitization.

ge Dosage: One tablet with breakfast
or every other day.

bility: White, single-scored tablets of
. and aqua tablets of 50 mg., in bot-
100 and 1000. (B)46-230-D

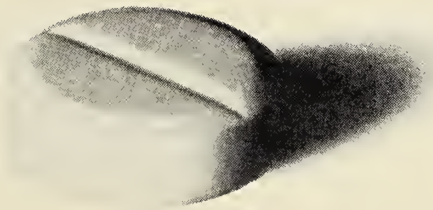
**ll details, please see the complete
ribing information.**

Pharmaceuticals
on of
Chemical Corporation
ey, New York

Here's the Hygroton they don't have to halve

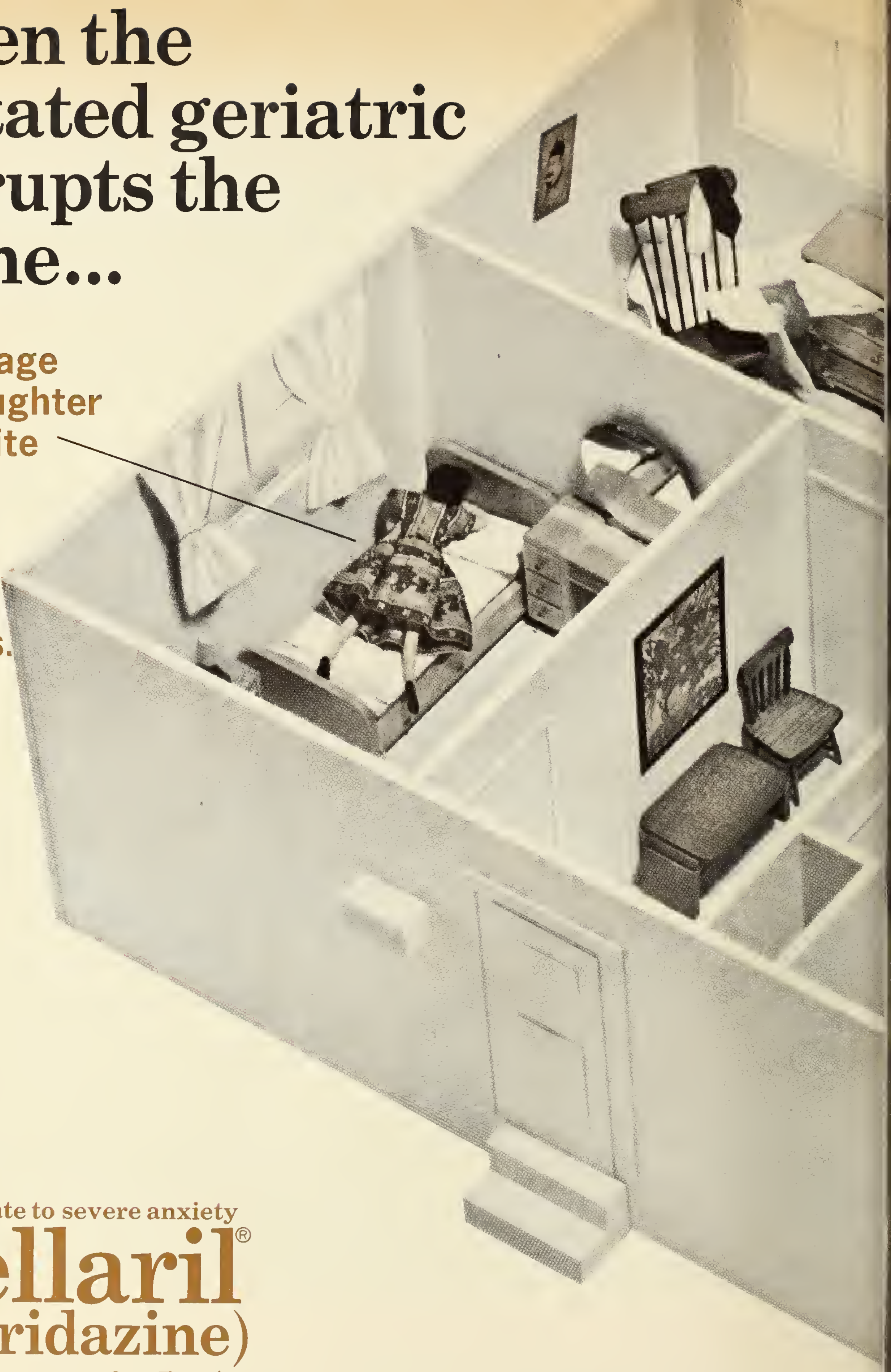
New Hygroton 50 mg. from Geigy

to go with the Hygroton 100 mg. you know



HY-5406

When the agitated geriatric disrupts the home...



His teen-age granddaughter won't invite friends home because of his outbursts.

for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ

His slovenly room and habits create more tension.

His disturbances at the table make every meal a nightmare.

His daughter can't please him. There is "just no living with him."

See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

hange was so obscure that even our fine profes- ional staff took it to be a mere conforming and echnical amendment until 2 days ago when the hange was pointed out for what it was — a ubstantive change which is a matter of serious oncern to the States.

The very innocent-looking language on lines 19 nd 20 of page 28 of the bill goes like this:

> (3) the second sentence of such section 314(e) amended by striking out "or (2)."

It is not to be found in the section which deals ith section 314 of the Public Health Services ct but in the section which deals with section 04. But the drafters knew it was there and said ot a word until the discovery was presented to hem, and then they admitted it was a substantive hange. This is a shoddy practice, and the com- ittee and this House have reason to be suspicious f the claims for reasonable administration made y a department which allows such practices.

Here is what it really does. The project grants hich were for stimulating and supporting for n initial period new programs became something ifferent and obviously broader. It now reads "de- eloping," rather than "stimulating," and sup- orting for a period new programs of health serv- es — including related training. Having changed e nature of these particular project grants, the epartment then removed the words "or 2," thus aking it possible to completely sidestep and nore the wishes of the State government in the ea where the new program was to be carried ut. It could — and in view of the means by which e authority was sought, probably would — carry ut programs wherever it wished even in the face f outright opposition by the State to such ac- vities.

If a new program being developed and sup- orted by HEW for its own reasons is not con- stent with the plan of the State government, nd particularly if it is definitely inconsistent or ntrary to the policy of that State government, it hould not be allowed to proceed. By accepting is amendment we are merely returning to the atus of the act as it now exists and which, until ow, everyone thought would continue to exist. would merely require that these pet programs f HEW must be cleared with the State and be onsistent with the plans of that State.

Mr. STAGGERS. Mr. Chairman, will the gen- eman yield?

Mr. WATSON. I yield to the gentleman from Vest Virginia, the chairman of the committee.

Mr. STAGGERS. Mr. Chairman, in response the gentleman from South Carolina, I would like to say this was not discussed in the committee and there was not sufficient testimony given on this point. I would be willing to accept his amendment and support this, and send it to the Senate and let them have hearings on it.

Mr. WATSON. Mr. Chairman, I appreciate very much the help of the chairman of the committee.

I would like to say this one further word about how this situation developed so that other committees might be alerted to such eventuality. We relied upon the Department for various technical and conforming amendments. Our able staff — and I yield to no committee as far as the dedication and ability and hard work of our committee and staff — did not find this so-called technical change, which was incorporated into the bill by the Department, was indeed a substantive change. We subsequently discovered this very serious substantive change and I am glad to know the chairman will agree with us in correcting this. Frankly, with the correction of this, it will leave the bill exactly as it was intended.

THEN AND THEREAFTER

(From Vol. 1, No. 2, Econogram, *published by Medical-Dental-Hospital Bureaus of America)*

When comprehensive health service was being talked about in England during 1942, Sir William Beveridge said that "it will diminish disease by prevention and cure."

Also, costs were to decrease.

Furthermore, Mr. Aneurin Bevin proclaimed, "This will place this country in the forefront of all countries of the world in medical services."

HOWEVER, hospitalization and deaths are reported to have increased by 60% since 1949 whereas population has increased by only 9%.

No comment necessary!

NOTED AND QUOTED

My own experience is that once a story has been written, one has to cross out the beginning and the end. It is there that we authors do most of our lying.

Anton Chekhov

* * *

Lawsuit: A machine which you go into as a pig and come out of as a sausage.

Ambrose Bierce

* * *

. . . . a speech to be immortal doesn't have to be eternal.

Muriel Humphrey

easy
does
it!

tear, moisten, compare—that's all!

M 73
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TES-TAPE*
Urine Sugar Analysis Paper
Protect from direct light, excessive moisture, and heat
Lilly
FOR URINE SUGAR
ANALYSIS ONLY
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Say you saw it in Michigan Medicine

Editor's Note: This article is written in lecture — conference style, and offers comments made by the three participants at the University of Michigan Medical Center Gynecology Clinical Conference, March 15, 1967.

Gynecology Clinical Conference: Pelvic Exenteration

BY GEORGE W. MORLEY, M.D.
S. MARTIN LINDENAUER, M.D.
JOSEPH C. CERNY, M.D.
ALL OF ANN ARBOR

Doctor Morley:

We intend to discuss with you an important form of therapy designed to benefit those patients who have recurrent carcinoma in the pelvis — namely pelvic exenteration. In order to emphasize the team approach to pelvic exenteration we have divided this presentation into three parts, and we will discuss the gynecologic, general surgical, and urologic aspects related to it.

It is obvious that en bloc removal of the bladder, rectum, distal ureters, female productive organs, vagina, vulva, and the pelvic lymph nodes followed by the preparation of a colostomy and a "bladder" conduit of some type is an extensive procedure, but one must realize that it is directed towards a cure and not just palliation. Only rarely is some form of exenteration performed to rehabilitate patients suffering from irradiation necrosis or to control hemorrhage which can be treated in no other way.

Doctor M. R. Abell of the Department of Pathology reported recently that he was pleased with the aggressive approach towards the treatment of recurrent carcinoma of the cervix, since this type of lesion remains confined to the pelvis for a considerable period of time. He emphasized that carcinoma of the cervix grows along the planes of least resistance and in continuity into the surrounding tissues long before it spreads beyond the confines of the pelvis and, therefore, beyond the limits of irradiation and/or surgical therapy.

THERE ARE THREE basic types of pelvic exenteration which are performed for recurrent pelvic malignancy — anterior, posterior, and total; however, the type to be performed is decided upon at the time of the surgical exploration.

Initially, the surgeon "hopes" to perform a curative procedure without the sacrifice of both bladder and rectum, but as greater experience is gained, he tends to favor total exenteration as the treatment of choice for several reasons. First of all, a lesser procedure may result in incomplete removal of the neoplasm since tumor cells may be seen microscopically in adjacent tissues which because of fibrosis and scarring could not be detected by gross examination.

Secondly, the incidence of fistula formation is significant since practically all of these patients have had preoperative irradiation which has compromised the blood supply to the remaining pelvic structures prior to the operation.

Thirdly, if a second procedure is indicated for

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correction of a urinary or rectal fistula, the involved pelvic tissues cannot usually be excised at the time of diversionary therapy because of the poor condition of the patient and the acute inflammation present even though this tissue might contain unrecognized tumor cells.

Lastly, conservative surgery is paradoxical when operating for cancer as expressed in the old surgical principle, "the smaller the lesion, the greater the procedure." Most of the contributors in this field support this philosophy. This in no way implies, however, that total exenteration is done at the exclusion of all other procedures since anterior exenteration is still an excellent form of therapy and in Brunschwig's series it was performed in over 25 percent of the cases. One must also keep in mind the Wertheim radical hysterectomy and pelvic lymph node dissection in the treatment of early recurrent or radio-resistant carcinoma of the cervix which does not involve either the bladder or the bowel.

Brunschwig[1] at Memorial Hospital in New York has performed over 1,000 exenterations during the past 20 years. Of the 377 patients operated upon for recurrent carcinoma of the cervix that have been studied for five or more years, there was an 18+ percent operative mortality and an 18+ percent five-year survival. In a more recent series from 1958 to 1962 he reports a decrease in operative mortality to 11 percent. Brunschwig reports a 13.4 percent five-year survival for recurrent carcinoma of the endometrium. This coincides with the impressions of others since carcinoma of the endometrium, although it has a high survival rate with primary therapy, tends to leave the pelvis earlier than carcinoma of the cervix if the primary therapy has not been successful. Patients with carcinoma of the cervix usually die from complications of ureteral obstruction, whereas patients with carcinoma of the endometrium often die of complications due to distant metastases.

Ingersoll and Ulfelder[2] at Harvard report a 15 percent operative mortality and a 23.3 percent five-year survival in 73 cases of recurrent carcinoma of the cervix.

AS REGARDS GENERAL principles, I would like to endorse first and foremose the team approach to this procedure. Though some surgeons do the entire procedure themselves, we feel that the team approach is preferred since whatever is new in surgical techniques, etc., is known first to the specialist in his own field. Furthermore, the responsibility for the patient's care is shared not only in the operating room, but in post-operative care as well as in programming the future rehabilitation of these patients. It is my personal belief that these patients receive better care, and, therefore, we obtain better results when we adhere to this philosophy.

We feel that patient selection is very important. The patient's age is considered even though we do not have a dividing line based on age itself. Nevertheless, we are more apt to operate upon a 33-year-old with a questionably resectable lesion than a 70-year-old with similar involvement since the surgical mortality seems to rise in patients over 50 years of age.

The type of lesion is of great importance. Most procedures are performed for recurrent carcinoma of the cervix; however, some are performed for recurrent carcinoma of the endometrium. Only rarely is this type of surgery indicated in recurrent carcinoma of the vulva, and most patients with recurrent carcinoma of the ovary are not candidates for this type of surgical intervention.

In evaluating the patients further, we next consult the general surgeon (Doctor Lindenauer) who reports his impression after pelvic examination, sigmoidoscopy, and a review of the barium enema. The urologist (Doctor Cerny) is similarly consulted, and his opinion reflects his cystoscopic examination and review of the intravenous pyelogram. When indicated, an internist is consulted. Finally, the opinion and acceptance of the procedure by the patient is required before any further steps are taken. Both she and her nearest of kin are informed in non-medical terms of what is to be done, what will be removed, and what will be required of her in the future. Consultation with a psychiatrist would be requested if indicated, but to date this has not been necessary in our patients.

IN CONSIDERING THE surgery itself, several questions come to mind.

When to do it? We feel that pelvic exenterative surgery should be performed when all of the above criteria are met and the patient endorses such an undertaking.

Where to do it and who should do it? I am a strong supporter of the regional cancer center program and personally believe that this type of therapy should be carried out in such a center. Furthermore, the care of the patient with recurrent pelvic neoplasm should be in the hands of interested, well-trained, and aggressive specialists who have extensive physical facilities, broad consultative services, and complete paramedical aid immediately available to them. In addition, this form of ultraradical surgery should be under the direction of physicians who are sufficiently trained to manage the many ramifications of this type of treatment so that the patient not only receives adequate operative therapy, but also receives expert postoperative care and vigilance which is not always readily available in community hospitals. The operation, although extensive, covers a short period of time when compared to the actual hours spent in the preoperative and postoperative care of these patients. The long-term follow-up care can be demanding. If one is to initiate therapy for these patients, then one must be prepared to accept the responsibility for the long-term rehabilitation if the procedure is successful or the long-term terminal care if it fails.

Another question comes to mind.

Should you do it? There are two schools of thought. Proponents of this program feel that it definitely should be done and are pleased that there are physicians interested in this form of therapy. These physicians feel that the survival rates are significant, and I suspect that our statistics will support a 20 percent to 25 percent five-year survival. This compares favorably with the survival rates following the surgical treatment of carcinoma of the stomach, kidney, lungs, and pancreas. The patient, of course, is also a proponent since she gives consent for the operation. One patient recently said, "Let's get at it."

THIS FORM OF THERAPY is not without opposition, and the opponents are to be encouraged so that no one becomes too enthusiastic or unrealistic about the benefits that may occur. These physicians challenge the results and question the natural history of the disease as it relates to our therapeutic results. Although I cannot report the statistics on this today, it is my impression and the impression of others that we are definitely increasing the survival rates with this approach. Opponents also feel that these patients experience a "living death" after they have been subjected to the various diversionary procedures required. I do not believe this to be true since none of our patients has said that they were sorry we had performed the operation. Lastly, opponents report that once a patient does not respond to primary therapy that her prognosis is extremely guarded even though another modality is employed. This is certainly true, but further therapy should not be abandoned since the original lesion may have been radioresistant or inadequately treated or too extensive to be treated completely.

After the initial workup has been completed, the patient is presented to the Gynecology Tumor Conference. The history, physical examination, and the results of all laboratory studies are reviewed by the Tumor Board composed of a gynecologist, radiation therapist, and pathologist from the senior staff. It is important to note that *all* patients with gynecologic malignancy seen at the University of Michigan Medical Center are presented to this board for final recommendation.

In patients with recurrent disease there must be histologic proof of recurrence, and the details of the previous therapy must be available. Oftentimes a recurrence is obvious and can be documented by a routine biopsy. On occasion we must utilize needle biopsy to obtain tissue from suspicious areas on the lateral pelvic wall.

With all of this data available, we then decide whether or not this patient is a candidate for pelvic exenteration. Oftentimes the decision is clear-cut — the lesion may be obviously too extensive, *e.g.,* "a frozen pelvis," or, the recurrence is sufficiently localized to be considered resectable. When one is in doubt about the extent of the recurrence, then an exploratory celiotomy is recommended. After the abdomen is opened, the entire peritoneal cavity is explored for possible metastases. A biopsy of any suspicious areas in the liver, omentum, or periaortic nodes, etc., is prepared for frozen section examination. Any suspicious areas within the pelvis which are considered beyond the surgical limits of resection are also examined in this manner. Should any of these specimens show evidence of malignant disease then the procedure is terminated.

It must be remembered that exenterative therapy is undertaken with cure in mind. This is *not* a palliative procedure. Unfortunately, there are patients with some types of metastatic disease that cannot be detected in any other way. The "court of last resort" oftentimes is at the operating table. We must be positive about the extent of the disease!

During the past two years 76 patients with recurrent pelvic neoplasm have been presented to the Gynecology Tumor Conference to be considered for possible pelvic exenteration. Twenty-eight patients were considered inoperable because the disease was outside the pelvis *e.g.,* positive supraclavicular nodes, and 22 patients were considered inoperable because of extensive disease within the pelvis. Of the remaining 26 patients who were considered candidates for pelvic exenteration, eight were treated with exploration only since metastases beyond the limits of surgical resection were demonstrated on frozen section examination. Eighteen patients were treated with some form of pelvic exenteration. Therefore, approximately 25 percent of the patients considered by the conference were actually treated with pelvic exenteration.

Now I wish to introduce Doctor Lindenauer, of the Department of General Surgery, who will present some of the surgical principles employed and some of the statistics from our institution.

Doctor Lindenauer:

There are two points to keep in mind in terms of improving survival in pelvic exenteration. The first is case selection, which Doctor Morley has amplified, and the second is the experience of the operator. This is not a procedure that can be done by the casual surgeon. It should be undertaken by only a few interested, aggressive, and optimistic surgeons who are willing to devote themselves to a procedure of this magnitude and to care for these patients postoperatively and through their period of rehabilitation and adjustment.

Patients undergoing pelvic exenteration have a complicated course and represent a tremendous burden in terms of nursing and physician care, and I feel strongly that there is a place for a specialized center to deal with patients who undergo pelvic exenteration.

Let us consider for a moment some points of technique and some of the problems we have encountered. First on the list is blood replacement. As you can imagine, these people require a lot of blood replacement, and on the average this has been about 4,000 cc. Pelvic exenteration is an extensive procedure, and since a significant amount of blood is lost, close attention to blood replacement is required.

Intestinal obstruction has plagued us. Three of our patients have had intestinal obstruction, but fortunately all of them were managed non-operatively. Two of our patients have had a significant pulmonary embolus, but both of them responded well to medical therapy. Infection is an ever present problem. We transect the intestinal tract as well as the urinary tract, and we have had our share of problems with infection and urinary tract infection. We have not seen the commonly described problems of bowel fistula. We have had no ureteral leaks and have been fortunate in that we have had no patients with acute renal failure.

THE FIRST POINT that I would like to make in terms of technique is economy—economy of time and economy of blood loss. There are a few technical features that we have evolved which we feel are useful. We use the "ski position," which is a modified lithotomy position with the legs on wood extensions which are much like skiis. This allows us simultaneous access to the abdominal operating area and the perineal operating area. It allows us to palpate and operate trans-abdominally and via the perineum at the same time. This also avoids turning the patient in the middle of the procedure which is required in a standard abdominal and perineal approach. If the blood volume is not adequately replaced, this is the time a cardiac arrest will occur, and such a case did occur here a number of years ago. Another feature in economy of blood loss is the practice of routinely ligating both hypogastric arteries which incidentally has not caused any trouble with gluteal claudication or ischemia. A further point in the economy of time is the sigmoid conduit a subject which I shall leave for Doctor Cerny.

We have been concerned about the peritoneal floor closure which can be managed in a variety of ways. These include packing with dry gauze alone, packing with gauze behind a rubber dam, or utilizing additional aids such as drains or suction catheters, etc. We have utilized a peritoneal flap which is also referred to as a peritoneal sling or hammock which has been described by Doctor Mattingly[3] to close the peritoneal floor. When this is possible, earlier ambulation is encouraged since the intestines are confined within the peritoneal cavity. It is also a useful technique in preventing intestinal obstruction, since loops of small bowel may readily become adherent to the raw pelvic floor when peritonealization cannot be carried out. Beneath the peritoneal flap we utilize gauze packing for hemostasis and support. This is removed in three days and then is repacked daily until there is adequate granulation tissue present. We usually excise all of the vagina, perineal body, vulva, and anus in continuity in order to provide a generous margin around the tumor.

THE RECENT INNOVATION of the so-called inferior vena cava filter as described by Doctor DeWeese[4] a number of years ago has interested us in the prevention of pulmonary emboli. The vena cava is readily accessible, and by the use of a silk suture one creates a filter in the vena cava which allows the blood to continue to flow but traps the large embolus. I am sure that we have a greater number of pulmonary emboli than is recognized; this is a prophylactic attempt to avoid this complication. One is rather reluctant to anticoagulate a patient with such a large raw pelvic wound. In terms of prophylaxis we also utilize prophylactic antibiotics. This is a controversial issue, but there is data to support the use of prophylactic antibiotics in procedures that transect potentially contaminated areas such as the gastrointestinal and genitourinary tracts.

Monitoring the central venous pressure has been very helpful in assessing the blood volume. We have had one problem with over replacement in a patient who went into congestive heart failure. We have been pleased with the routine use of cen-

al venous pressure monitoring in the operating
oom and in the acute postoperative period as a
uide to the adequacy of volume replacement. We
tilize a large volume of intraoperative salt re-
lacement in addition to blood replacement since
here is an extensive salt deficit in the face of mas-
ve blood loss. These patients lose a considerable
mount of serum from the extensive operative
rface which requires significant salt replacement
n the acute postoperative period as well. Temper-
ture monitoring is important since these people
ave large areas of skin and viscera which are ex-
osed. They lose body heat rapidly and require a
rge volume of blood which has been recently re-
igerated. We have utilized a warming blanket, a
lood warmer, and an esophageal temperature
onitor to avoid the problem of hypothermia and
ardiac arrest which may occur secondary to it. An
pper extremity intravenous portal is essential
hen one is operating in the pelvis as one can
adily visualize the difficulties involved in blood
placement with a rent in one of the iliac veins.

ALTHOUGH OUR SERIES is not large, there
ave been 43 pelvic exenterations performed at
he University of Michigan Medical Center since
953 with 13 (30 percent) of them performed
uring the past 21 months. Since the statistics
athered from such a small series are not partic-
larly meaningful, we have chosen to speak more
bout problems and technique rather than about
ur statistics, which will be presented at a later
ate. We are happy to report, however, that since
he team approach was initiated, we have had a
arked reduction in operative mortality and mor-
idity. In addition, the operating time and the
lood loss has decreased significantly. The course
f most of these patients is somewhat prolonged
nd involved, but we have been happy with our
esults and feel encouraged to persist in this type
f combined or team approach. In keeping with
hat philosophy I will now turn the discussion
ver to Doctor Cerny.

Doctor Cerny:

The preoperative urologic evaluation of a pa-
ient being considered as a candidate for pelvic
xenteration should follow an orderly sequence.

The first step, that of a good history and physi-
al examination, may yield significant information
bout possible neoplastic spread to the urinary
ract. Patients who have neoplastic bladder inva-
ion may complain of urinary urgency and fre-
quency. Very often tumor spread to the bladder
will produce a bacterial cystitis with characteristic
ymptoms; hematuria commonly is associated with bladder invasion. The possibility of bladder involvement can often be determined by a good bimanual pelvic examination after the patient's bladder has been emptied of urine. Induration or fixation of the bladder as it is compressed between the vaginal examining hand and the anterior abdominal examining hand is strongly suggestive of involvement. The urethra and vesical neck are easily palpable along the anterior vaginal wall.

Ureteral obstruction within 5-8 cm of the uretero-vesical junction occurs commonly in carcinoma of the cervix with extension. If significant hydroureter and hydronephrosis has developed, patients may complain of flank pain or nausea and vomiting. If obstruction is severe and of long duration, azotemia may be present and uremic symptoms may be elicited. Physicial examination often demonstrates costo-vertebral angle tenderness or palpable hydronephrotic kidneys.

THE SECOND STEP, that of urinalysis, is helpful. A finding of red blood cells, white blood cells, casts, albumin, or bacteria indicates urinary tract abnormality and may be indicative of neoplastic invasion.

THE THIRD STEP is that of determining renal function. Without belaboring the point, I feel that the most commonly used real function test, the blood urea nitrogen, is a poor test for many reasons which time does not permit us to enumerate. Similarly, the serum creatinine is often difficult to interpret and may be misleading. The best renal function studies available in our hospital are (a) the 24-hour endogenous creatinine clearance, which measures glomerular function, and (b) the 15-minute PSP excretion, which measures tubular function and peritubular blood flow.

Any patient who is to undergo major surgery, and particularly patients such as those considered for pelvic exenteration with its significant blood loss and the probability of ureteral diversion, must have the state of renal function accurately determined by these two tests.

THE FOURTH STEP consists of obtaining excretory pyelograms. Here we are looking for evidence of ureteral obstruction with hydronephrosis and hydroureter as well as for possible bladder involvement on the cystogram phase of the IVP. Knowing the degree of ureteral dilatation is helpful in planning the optimal type of urinary diversion for a particular patient.

THE FIFTH STEP in the pre-operative evaluation of these patients is cystoscopy. This should be done under general anesthesia to permit biopsy if necessary. Obviously one is looking for evidence of bladder invasion. Unfortunately neoplasms invading the bladder muscle do not always involve the bladder mucosa, and the cystoscopist may see only evidence of extrinsic pressure upon the bladder, with an entirely normal mucosa. If the degree of bladder invasion is not great, therefore, it is entirely possible for the cystoscopic examination to be interpreted as normal. Cystoscopy is an important and valuable part of the pre-operative evaluation of these patients, but it must be interpreted with care and the knowledge that a negative examination does not exclude neoplastic involvement.

Operative Techniques

As Doctor Morley has commented, the final determination of the degree of urinary tract involvement by the pelvic neoplasm is made at the time of surgical exploration. Ideally, we would hope to find the urethra, bladder, and ureters uninvolved, in which case the urinary tract could be left intact and a posterior exenteration performed. Usually, however, there is neoplastic invasion, and extirpation of part or all of the lower urinary tract is indicated.

SEGMENTAL CYSTECTOMY, *i.e.,* removal of only that portion of the bladder which has neoplastic infiltration, may sometimes be feasible. In general, though, this is not a good procedure because of the possibility that excision of involved bladder may be incomplete and residual neoplasm left behind. Furthermore, the neoplasm usually involves the posterior bladder wall and trigone, and segmental resection of this portion of the bladder is a formidable operation requiring ureteral implantation. In addition, the concept of less than total extirpation of an involved viscus and the potential for leaving residual neoplasm is alien to the aggressive approach necessary if one hopes to obtain a cure for some of these patients.

In most cases, then, total cystectomy, urethrectomy, and distal ureterectomy (2 - 3 cm or higher if necessary) is done as part of the exenterative procedure. The ureters, as they are mobilized, should be handled with care to avoid injuring blood vessels in the distal segments since successful uretero-enteric anastomosis depends upon adequate distal ureteral blood supply.

CUTANEOUS URETEROSTOMY is a relatively rapid and simple technique of urinary diversion. The ureters are brought out extraperitoneally or transperitoneally and anastomosed directly to the skin of the abdominal wall. If the ureters are dilated, thickened, and have increased blood supply as a result of obstruction, the long-term results of ureterocutaneous anastomosis can be satisfactory. If the ureters are of normal caliber, however, long-term results are less satisfactory, and complications such as stricture at the skin level, need for prolonged intubation, and pyelonephritis are common.

In general, although cutaneous ureterostomy offers the advantage of rapidty and ease of performance, which may be important in the extremely poor operative risk patient, it is the least desirable of the various kinds of urinary diversion.

URETERO-SIGMOIDOSTOMY is feasible only in anterior exenteration where the rectum and sigmoid have been left intact. This type of diversion, as in cutaneous ureterostomy, offers the advantage of technical ease and rapidty. The patients are usually happy with this diversion because they do not need to wear a urinary collecting apparatus and are continent of urine by simply voiding per rectum every 2 to 3 hours. Unfortunately, many patients with uretero-sigmoidostomy develop ascending pyelonephritis and hyperchloremic-hypokalemic acidosis as a result of reflux of feces and urine up the ureters, and this form of urinary diversion has fallen into disfavor amongst most urologists.

Another technique of diversion in which we have been particularly interested is the sigmoid loop or conduit. In this procedure a 6 to 8 inch segment of sigmoid is used to create a pouch into which the ureters are implanted. The proximal end of the pouch is closed, and the distal end is brought out as a stoma in a suitable location on the anterior abdominal wall. The advantage of this procedure in total pelvic exenteration is that the sigmoid is readily available, and a separate ileal loop and an additional bowel anastomosis are thus avoided. Although this form of diversion is not popular in the United States, it has been in wide use in the British Isles, and we consider it the diversion of choice in total pelvic exenteration.

ALL OF YOU ARE FAMILIAR with the standard ileal loop form of urinary diversion where a segment of distal ileum is used to create a pouch for ureteral implantation and the distal end is brought out to the abdominal wall. This is an excellent form of urinary diversion. We have not employed it often in our series, however, because of the advantages of sigmoid loop diversion.

A technique of diversion which we have not used is the so-called "wet colostomy." Although feces coming from one stoma, a colostomy, can be easily managed, and urine coming from another stoma, a sigmoid loop, is easily collected, a combination of feces and urine emerging from the same stoma is highly odoriferous, difficult to manage, and objectionable to most patients. For this reason we have not chosen to use the "wet colostomy."

Doctor Morley:

I would like to close with a word about the rehabilitation of these patients. After the patient has "weathered the storm" of the immediate postoperative period and after the large vacant pelvic vault begins to fill in, we then must consider the future marital activities of these patients who in time will want to live as normally as possible. About four weeks after surgery the patient is fitted with an obturator which she learns to insert and care for when taking her sitz baths and performing her irrigations. Frequently, the obturator may be left out during the day.

The pelvic tissues fill in around the obturator which ideally is worn for about six months. If there is no evidence of recurrence at that time, we then perform a vaginoplasty using a split thickness skin graft, taken from either thigh area. This procedure can be performed sooner, and in the future we may do it at 2-3 months, but psychologically I think it is important to get the patient out of the hospital for a period of time.

IN CLOSING, WE continue to be enthusiastic and optimistic about the treatment of recurrent pelvic malignancy and feel that our results warrant a continuing effort to offer such patients a second chance for survival.

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Syphilis Casefinding Through the Laboratory Reporting System

BY GEORGE PICKETT, M.D., M.P.H.
ELOISE

ABSTRACT — Laboratories performing serologic tests for syphilis in Michigan must report positive test results to the local official health department. The venereal disease investigator attempts to locate and bring to treatment patients whose results indicate the possibility of infectious syphilis.

Of 374 new cases of syphilis brought to treatment in Wayne County, 97 (25.9 percent) were found through the laboratory reporting program. Three cases illustrating both the successes and the failures of this program are discussed.

Twenty-six states including Michigan require that any laboratory which performs serological tests for syphilis must report positive results to the official health department.[1] Currently the Wayne County Health Department receives reports from 43 laboratories located in Wayne County which are registered with the State Health Department. These reports require a certain amount of clerical work in the performing laboratory and a considerable amount of file-searching and correspondence by the health departments. It is of interest to review recent experiences with this program in order to evaluate its effectiveness as a casefinding procedure.

Methods

Michigan law requires that positive tests for syphilis, gonorrhea, and any test indicating the presence of the Ducrey bacillus or Donnovan bodies must be reported to the local health department at least twice monthly.[2] Positive darkfields should be reported within 24 hours. If no positive tests are performed during any given month, a statement to this effect is to be submitted before the fifth usual working day of the month following. These forms are reviewed in the Wayne County Health Department in search of "hot bloods," and for any patients who have been reported previously. The term "hot blood" refers, in general, to any reactive test with a high titer. If such a case is found, action is initiated from the Wayne County Health Department to begin an epidemiological investigation and to insure that the patient is under treatment. The forms are then forwarded to the State Health Department where a master registry is checked looking for the previously reported patient. After this, a report is initiated in Lansing and returned to the local health department requiring a diagnosis and a disposition for each case listed on the laboratory report form.

In the Wayne County Health Department, if the physician's name is noted on the laboratory report form, a letter is sent to the physician requesting information concerning the diagnosis and whether or not the patient has been treated. The report form to be completed by the physician is known as the V-76. There is, on the back, space in which the physician may request replacement penicillin from the health department and that a venereal disease investigator see the patient in order to search for possibly infected contacts. If no physician is indicated on the laboratory report form, the patient is contacted directly by the health department.

Results

The figures shown in Table I summarize some of the syphilis casefinding activities of the Wayne County Health Department for the period January 1, 1966, through April 30, 1967. For this 16-month period the Wayne County Health Department re-

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TABLE I

NEW CASES OF SYPHILIS
REPORTED TO WAYNE COUNTY HEALTH DEPARTMENT
BY DIAGNOSTIC CATEGORY

January 1, 1966, through April 30, 1967

DIAGNOSIS	TOTAL	NEW CASES BROUGHT TO TREATMENT THROUGH LAB REACTOR PROGRAM	
		Number	Percent of Total
Primary and Secondary	55	14	25.5
Early Latent	42	22	52.4
Late Latent	232	50	21.6
Congenital	13	4	30.8
Unstated	32	7	21.9
TOTAL	374	97	25.9

ived reports of 374 patients with syphilis placed nder treatment. Ninety-seven of these cases (25.9 ercent) were found through the laboratory re- orting program. Of the 374 cases, 55 (14.7 per- nt) were diagnosed as being either primary or condary syphilis, and 42 (11.2 percent) were agnosed as early latent. Fourteen of the 55 pri- ary and secondary cases and 22 of the 42 early tents were ascertained through the laboratory porting system. The fourteen cases of primary d secondary syphilis discovered through the boratory reports yielded, on epidemiological in- estigation, an additional six cases of primary and condary syphilis and three cases of early latent philis.

Discussion

Three examples of cases discovered through the boratory reporting program are cited to empha- ze the value of this program to the venereal dis- se control effort.

CASE 1. A 21-year-old male had a reactive DRL, the titer being 1:4. Considered a "hot ood," the results were telephoned to the vener- l disease investigator, who in turn notified the ysician and referred the patient to the physician r treatment. As the original examination was r purposes of employment, the patient had had intention of returning to the physician and ould not have been brought to treatment except r the laboratory reporting procedure. Following terview by the venereal disease investigator, two ntacts were named. One was the patient's wife ho was examined and found to have primary philis. The other contact was found, examined, agnosed as having secondary syphilis and treated. he case of secondary syphilis was considered the an's source contact, and his wife was considered "spread" contact. The wife gave no further contacts, but the original source named several. These were located and examined, and an additional case of primary syphilis was diagnosed and placed under treatment.

CASE 2. A 52-year-old male was discovered through the laboratory reporting program with a weakly reactive VDRL and a nonreactive RPCF. While the RPCF is considered an excellent test when positive, its sensitivity is such that a negative test does not rule out syphilis.[3] Since no physician was listed on the laboratory reporting sheet, the patient was contacted directly by the health department, and he and his wife attended the health department clinic. No history of a previous infection was obtained. However, the wife volunteered that she, too, had had this problem. She had a letter from a hospital stating the results of previous examinations including a negative FTA (Fluorescent Treponemal Antibody) test. The letter stated that her diagnosis was Biologic False Positive. It seemed statistically improbable that two people, non-related by blood, living in the same house, should both have biologic false positive blood tests. For this reason, repeat blood tests were performed on both husband and wife and sent to the Michigan Department of Health, Bureau of Laboratories, for an FTA test. Both tests were reactive, indicating the presence of a previous syphilitic infection. Upon review of the wife's hospital records, it was ascertained that the FTA done at that time (1964) was the FTA-200. This was a more dilute test which was developed in the course of the evolution of FTA studies in order to reduce the number of false positives. The FTA-Absorbed (FTA-ABS) test currently being performed is much more precise.[4-6] On re-questioning, it was ascertained that the husband had been hospitalized at the age of 18 with a rash and was treated with 40 daily injections of an unknown type. Since the adequacy of the treatment could not be verified, these two patients were diagnosed as late latent syphilis and were treated accordingly. It should be noted that the repeat examination of the husband's blood indicated a negative VDRL. It seems possible that the blood antibody level had dropped to such a degree that normal laboratory testing procedures failed to discover its presence. However, for a brief period of time and for some unknown reason, his titer became high enough to react in the serological laboratory following which the blood level again fell to a nonreactive level.

CASE 3. A 40-year-old male had a reactive VDRL and a positive darkfield examination. Unfortunately, the health department was not notified immediately, but one month later. While the patient was placed under proper treatment and may be considered as a treatment success, the one-month time lapse made an epidemiological investigation extremely difficult, and no source or spread contacts could be found. The case was, therefore, a treatment success, but an epidemiological failure.

These three cases illustrate at least three problems. The first case is quite common in a heavily industrialized area. Where there is a large population employed in industry with a high turnover rate, many pre-employment examinations are done without the establishment of a useful physician-patient relationship. When the blood test results are positive, there is no way for the physician to contact the mobile job applicant. Frequently, the patient remembers that the last time he had a blood test someone from an official government agency made inquiries as to his whereabouts. When he finds that a blood test was part of his pre-employment examination, he may once more disappear, frequently carrying with him an infectious case of syphilis or a latent untreated case. Secondly, the complexities of the presently available blood tests for syphilis are apparent. In many cases a reactive VDRL with a nonreactive RPCF has been interpreted as an indication of a biologic false positive test result. The third point illustrated in the above cases is the epidemiological failure which may have been due to the delay in reporting an obviously infectious case of syphilis.

Summary

The laboratory reporting program has played a valuable role in the venereal disease control program in Wayne County. During the most recent 16-month period, 97 cases were discovered through this program, and an additional nine cases were found following epidemiological investigation for a total of 106. Of the cases of primary, secondary, and early latent syphilis reported to the health department during this period, 36 (37.1 percent) were discovered through the laboratory reportin program. It seems possible that many laborato supervisors are not aware of the fact that this r porting program plays such a valuable role in t control effort. It is also apparent that failure t report rapidly any highly suspicious findings m result in an epidemiological failure and thus v tiate the control effort.

Acknowledgments

I am indebted to Mr. Michael McCabe, Venere Disease Investigator, who reviewed all of the dat and developed the statistical section of this repor

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CIENTIFIC ARTICLE

BSTRACT — Eighty-five cases of maternal deaths due vascular accidents were found in 486 cases registered the Maternal Tissue Registry established at The Uni- rsity of Michigan Medical Center. Amniotic fluid em- oli were the most common cause of death from vascular cidents. A clinicopathologic analysis of amniotic fluid nboli, subarachnoid hemorrhage, and dissecting aneu- sm of the coronary arteries is presented.

/ascular Causes Of Death in Pregnancy

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The development of better antenatal care, anti- iotics, and other therapeutic measures has led to decline in maternal deaths caused by hemor- age, toxemia, and infection. With this decline as come a relative increase in the more obscure uses of maternal death. Deaths due to vascular cidents represent a significant part of these lesser uses of maternal death. Approximately 10-20 ercent of maternal deaths are now secondary to me form of vascular catastrophe.[1]

Materials and Methods

A maternal tissue registry was established at the niversity of Michigan Medical Center in 1957 cooperation with the Michigan State Medical ciety Committee on Maternal Welfare, the Mich- an State Health Department, the Michigan So- ety of Pathologists, the Michigan Society of Ob- etrics and Gynecology, and the Michigan Osteo- thic Society. The registry is housed in the De- rtment of Pathology and collects and catalogues l cases of maternal deaths in which necropsies ave been performed. Until Devember 1966, 486 cases had been recorded in the registry. Eighty-five cases of deaths from vascular accidents serve as the basis for this report.

Results

The 85 deaths are shown in Table I. Sixty-six deaths resulted from some form of embolism, the most common being amniotic fluid embolism. We will limit our discussion in this report to amniotic fluid embolism, dissecting aneurysms of the coronary artery, and subarachnoid hemorrhage.

Amniotic Fluid Embolism

All of the 32 deaths caused by amniotic fluid emboli were confirmed by the examination of microscopic material obtained at necropsy.

All of the patients were over 30 years of age, and 12 were over 35.

The period of gestation ranged from 38 to 44 weeks; in 26 instances the period was 40 weeks or more. All but four of the 32 women were multiparous. Parity ranged from two to eight, and 28 patients were in labor when the accident occurred. In 18 instances labor was spontaneous, and in seven labor was induced with oxytocics. Three patients received oxytocics to augment their labor. Tumultous or unusually short labor (less than 1 hour) occurred in eight patients. Pertinent clinical

TABLE 1

Amniotic fluid emboli	32
Pulmonary arterial emboli	21
Air emboli	13
Cerebral hemorrhage	9
Ruptured berry aneurysm	5
Coronary arterial disease	2
Cerebral arterial thrombus	1
Dissecting aortic aneurysm	1
Ruptured aortic aneurysm	1
	85

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TABLE 2

Presenting Symptoms in Amniotic Fluid Embolism

Symptoms	No. of Cases
Dyspnea and cyanosis	18
Cardiac arrest	2
Grand mal convulsions	6
Shock	6

findings in the 32 patients are summarized in Table II. Seven patients eventually developed significant bleeding due to incoagulability of the blood.

Pathologic changes were most striking in the lungs. No striking gross changes were described. The majority of the lungs were severely congested and contained an abundant amount of edema fluid.

A prerequisite for the diagnosis was the discovery of elements normally found within the amniotic fluid in small branches of the pulmonary artery and in arterioles, usually consisting of squames, mucinous material, and lanugo hairs within the blood vessels. When material within the blood vessels was not easily seen with the hematoxylin and eosin stain, mucicarmine or alcian green stains materially aided in demonstrating the particulate matter within the vessels. Mucicarmine stains the mucinous material within pulmonary blood vessels a brillian red, and alcian green, a brilliant green. Changes within the lungs secondary to the occlusion of the smaller arteries and arterioles, intra-alveolar hemorrhage, and occasionally a hemorrhagic infarct, were present in a few cases. Most of the specimens showed only pulmonary edema.

The particulate matter of amniotic fluid wa sought in other organs. Squames were found within the renal glomeruli in one case, and in another within a large uterine vein. A smear of bloo taken from the right atrium of the heart at th time of necropsy showed squames in another patient.

Coronary Arterial Disease

Two maternal deaths were caused by coronar arterial disease. These are interesting because bot were due to dissecting aneurysms of coronary arteries. These cases have been previously reported.

The first case was that of a 40-year-old woman 2½ weeks postpartum, who had an acute episod of pain and collapsed while at stool. The patien was dead on arrival at a hospital. The second cas was that of a 36-year-old woman, 19 days postpartum, who while watching television complaine that she did not feel well, stood up, and collapse on the floor. She was dead on arrival at a hospita a short time thereafter.

Fresh dissecting aneurysms of the descendin branch of the left coronary artery were found i both cases at necropsy. The aneurysms were characterized by the presence of blood within th media separating it into two layers, and pressur exerted on the media by the hemorrhage occlude the lumina of the arteries.

Foci of mucinous change were found in th media of the coronary arteries in both cases. A myocardial infarct was present in the first case, involving the anterior portion of the left ventricula

TABLE 3

Subarachnoid Hemorrhage without Demonstrable Aneurysm

Age	Parity	Gestation	Pertinent Medical History	Toxemia
36	G5,P4	12 days pp*	Hypertension	0
39	G5,P0	34 weeks	Premature rom**	0
31	G5,P3	28 weeks	0	+
39	G6,P5	5 days pp	Hypertension	0
—	G8,P6	36 hours pp	Hypertension	+
35	——	12 weeks	0	0
29	G4,P3	6 days pcs***	Hypertension	+
35	G2,P1	32 weeks	Hypertension	+
42	G8,P6	18 weeks	Hypertension	0

*pp = postpartum
**rom = rupture of membranes
***pcs = post cesarean section

TABLE 4

Subarachnoid Hemorrhage with Cerebral Arterial Aneurysm

Age	Parity	Gestation	Pertinent Medical History	Toxemia
34	G1,P0	12 weeks	0	0
41	G12,P9	28 weeks	Hypertension	0
37	G5,P4	38 weeks	Hypertension	0
41	G4,P0	Term	0	0
23	G1,P0	40 weeks	Hypertension	+

myocardium, the anterior portion of the interventricular septum, and the anterior papillary muscle.

Subarachnoid Hemorrhage

Included in this group of patients are those whose subarachnoid hemorrhage was caused by the rupture of a vascular aneurysm or from undetermined causes. Those secondary to trauma or other definable cause were excluded. There were 14 cases in the maternal tissue registry.

The 14 cases were divided into two groups: nine cases in which aneurysms were not demonstrated at the time of necropsy (Table 3) and five cases in which aneurysms were readily demonstrated (Table 4).

The average age of the 14 individuals was 35 years. Gravidity ranged from one to 12 and parity from zero to nine. Nine patients had a history of hypertension. Five patients had signs and symptoms suggestive of toxemia of pregnancy.

Analysis of the data to determine the time during the 40 weeks of pregnancy the hemorrhage occurred showed: 0-12 weeks, two patients; 13-24 weeks, one patient; 25-40 weeks, seven patients; postpartum period (1 to 12 days), four patients.

Comment

The syndrome associated with amniotic fluid embolism was described 40 years ago, but it was not until 1941 that amniotic fluid embolism was established as a clinical entity. In that year Steiner and Luschbaugh[3] described the clinical entity and reproduced the symptoms associated with the syndrome in rabbits by the intravenous administration of amniotic fluid. They demonstrated the particulate matter from amniotic fluid within the pulmonary blood vessels.

Since 1941 numerous reports have appeared in the literature, and although the overall incidence of amniotic fluid embolism is low, it is an important cause of death during labor and the immediate postpartum period. In Michigan in a five-year period (1960-1965) there were 363 deaths due to direct obstetric causes, and of these, 32 were due to amniotic fluid embolism. This is an incidence of 1:33,952 livebirths, representing 8.8 percent of all deaths due to direct obstetric causes.[4]

Aguillon,[5] in a review of 60 cases of amniotic fluid embolism, characterized the syndrome as follows:

1. The clinical entity of amniotic embolism usually occurs in an older multipara who has borne a large baby after a difficult and prolonged labor.
2. The onset occurs during or just after delivery.
3. When the duration of symptoms is short, the predominant factors are respiratory distress, shock, and death. When prolonged, hemorrhage is a complicating factor with hypofibrinogenemia an underlying cause.

The 32 cases described in this report fall into the pattern described by Aguillon.

The only hope to decrease deaths due to amniotic fluid embolism lies in the recognition of predisposing factors, early clinical recognition of the syndrome, and prompt treatment.

The two cases of dissecting aneurysms of the coronary arteries in the Maternal Tissue Registry are of interest. This is a very rare entity. Brody[2] included these in his report of five cases of dissecting aneurysms of coronary arteries to bring to 20 the total number of cases reported in the literature. The observation of greatest interest to obstetricians is that four of five cases reported occurred in previously pregnant women. In addition, of 20 cases reported in the literature, 12 occurred in women, and of these 12, six were related to pregnancy and occurred in the postpartum period. Table 5 is a summary of the six cases.

Explanations for the occurrence of dissecting aneurysms of the coronary arteries have been offered, but no clinical or experimental data are

TABLE 5

Dissecting Aneurysm in Coronary Arteries of Postpartum Women (after Brody et al.[2])

Source of Data	Age	Sex	Location	Relation to Pregnancy	Other Possible Factors
Lovitt & Corzine	39	F	Anterior descending branch, left coronary artery	14 days postpartum	None
Wells	42	F	Anterior descending branch, left coronary artery	6 weeks postpartum	Labile hypertension
Brody, et al:					
Case 1	35	F	Anterior descending branch, left coronary artery	6 weeks postpartum	None
Case 2	40	F	Anterior descending branch, left coronary artery	2½ weeks postpartum	None
Case 3	36	F	Anterior descending branch, left coronary artery	19 days postpartum	None
Case 4	41	F	Anterior descending branch, left coronary artery	11½ weeks postpartum	None

available to support them. In lower animals there is a generalized loosening of the ground substance of the connective tissue during pregnancy which reaches a peak at the time of parturition. This is best demonstrated in the guinea pig and in the monkey. In the two cases described in this report, mucinous change in the media of the coronary artery was present. Mucinous change in the media is the classical lesion found in Erdheim's cystic medial necrosis of the aorta, which is thought to be responsible for a significant number of dissecting aneurysms of the aorta. Weakening of the wall of the artery by loosening of the connective tissue and mucinous change in the media, combined with the hemodynamic changes that occur in pregnancy, may be responsible for these lesions.

There is no apparent explanation for the occurrence of these aneurysms during the postpartum period. The increase in cardiac output during the postpartum period and during the obstetric Valsalva maneuver, combined with the previously described tissue changes, may be important in the pathogenesis of these aneurysms.

The fact that 30 percent of the cases of dissecting aneurysms of the coronary arteries reported in the literature have been in postpartum women justifies the inclusion of the disease in the differential diagnosis of sudden death in the postpartum period.

The consideration of subarachnoid hemorrhage in pregnant women raises a few questions:

1. Is subarachnoid hemorrhage more common in pregnant women?
2. What is the role of toxemia in the pathogenesis of subarachnoid hemorrhage?
3. What is the relationship of labor or other factors peculiar to pregnancy to the occurrence of subarachnoid hemorrhage?

Statistics show that the incidence of subarachnoid hemorrhage in pregnant woman is no higher than that of the general population.[6]

The higher incidence of patients in this series without demonstrable aneurysms leads to the consideration of at least two possibilities:

1. It may reflect the inability of pathologists to demonstrate small aneurysms at the time of necropsy.
2. The influence of toxemia in the pathogenesis of these hemorrhages.

Donnelly and Lock[7] analyzed 533 fatal cases of toxemia of pregnancy and found that the usual anatomic findings in patients who die with toxemia and who have had severe cerebral symptoms are small areas of hemorrhage and necrosis scattered throughout the brain. Bleeding was severe enough in some patients to stain the cerebro-spinal fluid. Only five patients in the series had massive intracranial hemorrhages at the time of necropsy, *i.e.*, hemorrhages similar to those which caused death in our group of patients. Subarachnoid hemorrhage, to the degree found in our patients, caused by toxemia is rare.

The trauma of labor is not a factor in the pathogenesis of subarachnoid hemorrhage in pregnant women. Only 12 percent of 122 cases of subarachnoid hemorrhages during pregnancy occurred in patients in labor.[8] In our group of patients none of the hemorrhages occurred during labor.

Hemodynamic changes during pregnancy seem to be the major factors in the pathogenesis of these hemorrhages. It has been shown that cardiac output rises at the end of the first trimester and reaches a peak during the 28th week of pregnancy.

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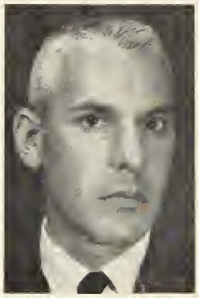
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The increase is approximately one-third greater than the normal and is distributed over a 14-week period. Cardiac output gradually falls and returns to normal levels at approximately the 40th week of pregnancy. With the onset of labor, new variables are introduced, and cardiac output increases by about 29 percent during the first hour after delivery and remains elevated until the sixth postpartum day.[9]

Seven of our patients had the acute episode of bleeding during the third trimester, and in four, it occurred during the immediate postpartum period. In another series of 122 patients, hemorrhage occurred 2 percent of the time during the first trimester, 37 percent during the second trimester, 12 percent during labor, and 25 percent during the first five days postpartum.[8] This falls nicely into the pattern of changes in cardiac output during pregnancy. However, in another large series, there was a high incidence during the 35- to 40-week period when the cardiac output is returning to normal, and a low incidence during labor and the postpartum period.[9]

Pregnancy does not influence the course or prognosis of cerebral arterial rupture. Maternal mortality from subarachnoid hemorrhage in a series of 79 patients was 46.7 percent whereas mortality in another review of patients including both sexes and all ages was 56.1 percent.[1]

A significant number of patients in both groups had a history of hypertension. However, as in dissecting aneurysms of the aorta and coronary arteries, hypertension does not appear to be a factor in pathogenesis.[2, 8]

Summary

A review of 85 deaths during pregnancy from vascular causes is presented. Clinical and pathological data on amniotic fluid embolism, dissecting aneurysms of the coronary artery, and subarachnoid hemorrhage are included.

Amniotic fluid embolism in this series is the leading cause of death.

Dissecting aneurysms of the coronary artery appears to be more common in pregnant women and are frequently an unrecognized cause of sudden death in postpartum women.

Subarachnoid hemorrhage in pregnancy does not differ significantly in incidence or sequelae from that which occurs in the general population.

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Synopsis: It is surprising how often women, in particular, complain of severe burning pain in the hand or hands which awakens them in the middle of the night. It is characteristic of these patients to walk around opening and closing their hands or placing them under water. The pain may extend to the little finger, forearm, and upper arm. It is, therefore, difficult for the physician to think that such symptoms arise from pressure on the median nerve at the wrist, and this is the reason that the diagnosis of the transverse carpal ligament syndrome is still so frequently missed. Pain of 15- to 20- years duration may be relieved overnight by a simple operation under local anesthesia.

The Carpal Tunnel Syndrome

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The syndrome resulting from compression of the median nerve in the carpal tunnel is still too frequently misdiagnosed. Although first described over a half-century ago, surprisingly, the carpal tunnel syndrome has not become well known until recent years.

General physicians, orthopedists, neurologists, and neurosurgeons often fail to recognize this type of median nerve neuritis because of symptoms they do not associate with pressure on this nerve at the wrist. Patients are sometimes subjected to neck traction, steroid therapy, myelography, scalenotomy, and other procedures, including psychotherapy, before the correct diagnosis is made and the surgeon sections the tranverse carpal ligament.

This operation usually provides dramatic relief of pain which may have persisted for as long as 20 years. The operation is simple and requires about 15 to 20 minutes under local anesthesia. There are few occasions when a surgeon has the satisfaction of providing such striking relief by so simple a procedure.

Clinical Features

The carpal tunnel syndrome may develop at any time after adolescence, but it usually begins during middle age. The disorder is far more common in women than in men; some physicians regard it as the commonest cause of chronic pain in women's hands and arms.

If the patient's occupation requires vigorous use of the hands and wrists and classic symptoms of median nerve neuritis are evident, the diagnosis of carpal tunnel syndrome is usually promptly established.

However, this clear-cut picture of median-nerve neuritis related to a specific occupation or activity is not generally present. The complaints of numbness, paresthesias, and pain, which would be expected to be limited to the distribution of the median nerve frequently affect all fingers and apparently include the little finger. Occasionally, when patients are asked to make a specific test at night when symptoms are more intense, they may find that the little finger is not actually affected. This point is not essential to the diagnosis, however, especially when other signs point toward the carpal-tunnel syndrome. The patient who carefully analyzes the pain may also report that only fingers are affected, the palmar surface of the hand being spared. This fits well with the anatomy of the region. The palmar cutaneous branch of the median nerve usually emerges through the antebrachial fascia proceeding distally superficial to, rather than under, the ligament.

Another point that sometimes obscures the diagnosis is that in addition to pain in the hand there is often a dull, aching, deep pain in the forearm, occasionally extending to the arm and the shoulder. This proximal distribution of pain from a

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lesion which presumably is caused by pressure on the median nerve at the wrist does not seem to accord with the neuroanatomic structure.

Other aspects of the history are important because objective signs of median-nerve dysfunction are usually slight, if present at all. In any case, the diagnosis should be established before significant objective signs of sensory or motor deficit develop.

Symptoms are most severe at night. The patient usually wakens around 2:00 A.M. with symptoms in one or both hands, usually more intense on one side. He may relieve the discomfort somewhat by pacing the floor, extending and flexing the fingers, and moving the arms about. Sometimes symptoms lessen when the hands are placed under cold water, or occasionally warm water. When the patient rises in the morning, pain, numbness, and stiffness persist for a brief time; the patient often complains of difficulty in dressing or holding a cup of coffee during breakfast. Symptoms then usually clear. Patients frequently complain of swelling of their hands in the morning, but this is usually not observed on examination and this complaint is probably a subjective sensation rather than true edema in most cases.

Reproduction of symptoms by flexion of the wrists for one or two minutes has been suggested as a test to establish the diagnosis of the carpal tunnel syndrome. Certainly this test may be positive, but often it is not, and some patients note similar intensification of symptoms after extension of the wrists rather than flexion.

Pressure on the median nerve at the wrist may or may not intensify symptoms, but this is not a significant point in the diagnosis of the carpal tunnel syndrome.

Laboratory Aids to Diagnosis

If bony abnormalities about the wrist are suspected, appropriate X-rays should be obtained; these are rarely informative, however.

Nerve conduction studies and electromyography occasionally aid in diagnosis. Delayed conduction velocity of the median nerve at the wrist is most important. Signs of denervation in the muscles of the hand supplied by the median nerve may also aid in diagnosis, although these do not differ from findings observed in median neuritis from other causes.

However, the typical clinical picture that we have outlined is so characteristic that the physician need not feel hesitant in making the diagnosis of carpal tunnel syndrome if electromyography is not available. Furthermore, if the history is typical, the patient should have surgical treatment even though normal or equivocal electromyographic results have been obtained. Indeed, patients have sometimes commented after the operation that as a "diagnostic test," the operation was less painful than a myelogram or electromyography.

Etiology

The transverse carpal ligament may obviously be enlarged, sometimes to the thickness of more than a half-centimeter. This agrees with the classic concept of hypertrophy of the transverse carpal ligament with consequent compression of the median nerve as the cause of the symptoms. The mechanism of hypertrophy of the ligament is not understood. However, the ligament is often normal in size in patients who show typical clinical findings and who are completely relieved of symptoms following section of the ligament. It appears that other factors may compromise the median nerve beneath a normal transverse carpal ligament and that these are also important in the development of the carpal tunnel syndrome. Most often no clear cause of the syndrome is found; however, it is known to develop following arthritis, fractures, diseases of tendons about the wrist, or in hyperpituitarism or severe hypothyroidism. Patients are often obese, and metabolic factors are further suggested by the diabetes noted in many patients. Often a diagnosis of diabetic neuritis results. The role of diabetes in the genesis of the symptoms is unknown, but the diabetic patient who has other typical symptoms of the carpal tunnel syndrome is usually relieved following surgery. We have observed the syndrome in association with the rare disorder "idiopathic edema." Commonly, the symptoms develop during pregnancy, often correlating with fluid retention. Presumably the edema compromises the median nerve in an otherwise normal carpal canal and transverse carpal ligament.

Doctor Joseph H. Adamkiewicz, Jr.,* has informed us of a group of patients with hereditary amyloid neuropathy under study at the Johns Hopkins Hospital. A number of the patients had typical signs of the carpal tunnel syndrome. Those patients in whom the ligament was sectioned were completely relieved of these symptoms.

Treatment

Surgery

If examination discloses infections of the hand with particular reference to the nails or fingers, surgery should be postponed.

Under 2 percent local anesthesia, an incision is made through the vertical mid-palmar crease, but is not carried quite to the flexion crease at the wrist (Figure A). The operation is simplified if after the skin incision is made the subcutaneous fat along both sides of the incision and over the palmaris fascia is excised with a curved scissors (Figure B). A mastoid retractor is used to spread the cut skin surfaces and to stop superficial bleeding. A tourniquet would cause pain under local anesthesia and is never used in the procedure.

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* Personal communication to the authors

The filmy palmaris fascia is incised vertically. Often a small muscle, the palmaris brevis, is attached to the lower portion of the palmaris fascia and must be transected vertically. The firm transverse carpal ligament is now seen and felt. With a small, round-bellied knife a vertical incision is made over the center of the exposed transverse carpal ligament (Figure C). At a depth of from 3 to 10 mm there is a sudden penetration following which a shiny yellowish sheath, which covers the flexor tendons and the median nerve as well, bulges into the incision. With a scissors entered at the point of penetration and superficial to the bulging sheath (Figure D), the remainder of the transverse carpal ligament is divided distally and proximally until there is no remaining pressure on the underlying structures (Figure E).

Actually, the median nerve is not always seen and need not be seen in this operation. It is superficial to the flexor tendons and lies over the radial side of the flexor tendons, but it is covered by a shiny yellowish sheath which cannot be distinguished from the synovial sheaths of the flexor tendons without needless dissection. No attempt should be made to free the median nerve in any way, once the transverse carpal ligament has been completely sectioned. The skin and subcutaneous tissues are then closed with a single layer of mattress sutures. The hand is wrapped in an elastic bandage for 24 hours and kept elevated. Although the site of incision may be quite painful for a day or two, the relief of pain in the great majority of patients is dramatic, becoming evident on the first postoperative night.

Other Methods of Treatment

The patient with only mild symptoms may be able to limit the use of the hand and avoid other specific therapy. Diuretics give variable relief of symptoms during pregnancy and in other states associated with fluid retention. In our experience, however, they have usually not given satisfactory relief.

Injections of hydrocortisone or prednisolone into the carpal tunnel has been advocated. We have had only limited experience with this method of therapy. The permanent relief provided by the simple procedure we have described suggests to us that surgery is preferable to injections about the median nerve.

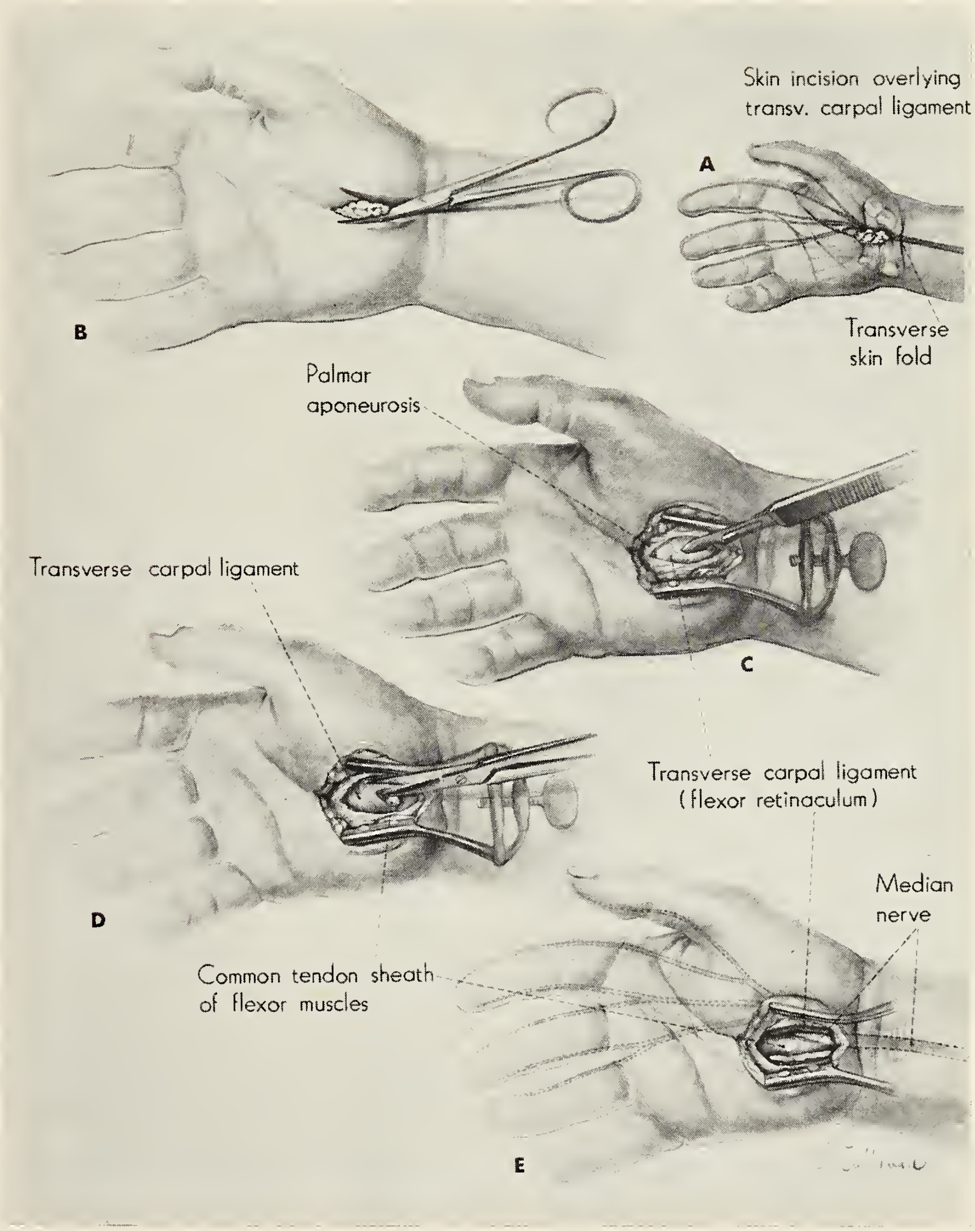
The following brief case histories will illustrate some of the features that have been described. The following patients were seen during one month in 1966:

Case Reports

CASE 1. The patient was a 55-year-old woman with a 25-year history of pain and numbness in the thumb, index, and middle fingers, and occasionally the ring finger, of the right hand. She said that initially the symptoms had occurred only at night, often wakening her from a sound sleep. After a few years the symptoms began to occur in the daytime also, particularly when she used her hand for work that stressed the muscles of the fingers and wrist. In 1953, during her fifth pregnancy, the symptoms became intense, and similar symptoms began to appear in the left hand also. In August 1953 a bilateral scalenotomy was performed. She did not use her hands for six weeks after surgery and assumed their condition had improved; however, as she resumed normal activities, the symptoms recurred. Every morning the discomfort persisted for an hour or two, and now there was stiffness in the forearms and arms, more pronounced on the right. In recent years she had noticed weakness of the right hand, particularly when picking up small objects. Treatment with various analgesics and trials of neck traction gave no relief.

Examination during 1966 disclosed mild atrophy and weakness of the thenar muscles on the right. Slight hypalgesia of the palmar surfaces of the right index and middle fingers was noted. Sectioning of the carpal ligament was performed on the right hand and two months later on the left. Following each operation relief of symptoms was noted the day of surgery. Six months later the patient was entirely free of symptoms on the left and had only mild residual numbness of the tip of the middle finger on the right. She has remained well to the present.

CASE 2. A 42-year-old housewife complained of pain and numbness of her fingers for over ten years. Symptoms were present in all fingers in both hands and were much worse at night, at which time she also complained of swelling of her hands requiring removal of her wedding ring when she went to bed. A vague pain was also present in the forearms. Symptoms wakened her and she would move her hands about and shake them to gain some relief. She found that by sleeping with her arms hanging over the sides of the bed she was somewhat more comfortable. Symptoms were equally intense in both hands and


Skin incision overlying
transv. carpal ligament
A
Transverse
skin fold
B
Palmar
aponeurosis
Transverse carpal ligament
C
D
Transverse carpal ligament
(flexor retinaculum)
Median
nerve
Common tendon sheath
of flexor muscles
E

Figures A, B, C, D, and E: Stages in operation for transverse carpal ligament syndrome. From CORRELATIVE NEUROSURGERY, 2nd Ed. (In press) Kahn, Crosby, Schneider, and Taren. Courtesy of Charles C. Thomas, Springfield, Ill.

forearms. Similar difficulty was experienced during the day following sewing or other work with her hands. Holding her arms outstretched or above her head aggravated the pain. When symptoms were present, she had difficulty in grasping and manipulating small objects. Otherwise, she did not complain of weakness. Through the years she had received psychotherapy, tranquilizers, and various mechanical measures aimed at relieving cervical arthritis and the scalenus anticus syndrome. Steroid therapy had also been used.

Examination in 1965 disclosed that the pulse did decrease when the head was rotated to the opposite side and the arm held outstretched. This finding had been observed by other physicians and was used to support the diagnosis of a thoracic outlet syndrome. Perception of pin prick on the palmar surfaces of the middle and index finger was slightly reduced bilaterally; otherwise, the neurologic examination was normal. Electromyography disclosed prolonged motor nerve conduction latencies at the wrists. Two operations were performed at 4-month intervals, cutting both carpal ligaments, which were clearly thickened. Relief of pain and numbness was prompt after each procedure, and the patient has remained healthy to the present.

CASE 3. A 52-year-old woman complained that for more than four years she had experienced intermittent numbness, burning, and stinging of the tips of her fingers on both hands, somewhat worse on the right. Symptoms occasionally wakened her at night and were severe after rising in the morning, persisting for over an hour. She also complained of weakness of her hands. Symptoms were particularly troublesome during the day when she performed her duties as a beautician. Eventually, she had to give up her job. She had no significant discomfort above her wrist, complaining only of a mild and vague discomfort in her forearms which apparently followed no definite peripheral nerve or root pattern. She took one-half grain of thyroid each day because of a low normal protein-bound iodine determination, but at no time were signs of myxedema present. Neurologic examination in 1966 was normal. Following section of the clearly thickened left transverse carpal ligament, symptoms improved within hours. The patient did not want to wait the usual month or two before surgery on the other hand. Two weeks later the right ligament was sectioned and was also found to be thickened. Symptoms again promptly abated. The patient remains well and has resumed work.

CASE 4. A 50-year-old housewife complained of numbness and tingling and pain in her hands, particularly the left, since the birth of her second child 19 years ago. Symptoms were worse at night and following the use of the hands during the day. Vigorous shaking of her hands gave some relief. Mild pain was present in the forearms and arms. The patient did have a psychiatric problem associated with asthma, and psychogenic diagnoses were entertained. However, a thoracic outlet syndrome was also considered. In 1950 bilateral scalenotomies were performed. Symptoms were not relieved. In 1957 another operation was performed on the right scalenus anticus muscle. Neurologic examination in 1962 was normal. At that time electromyography disclosed decreased conduction times in the median nerves and fibrillations in the right oponens pollicis. The consultant's diagnosis was carpal tunnel syndrome, but because of her general medical condition and emotional state, her physicians were reluctant to make a definite diagnosis and advise surgery. In 1966 clinical examination was negative, but section of a thickened left carpal ligament was performed. The patient complained of pain in the site of the incision, but her original symptoms cleared within a day. The incisional pain was relieved when the sutures were removed.

Conclusions

The clinical features of the syndrome involving compromise of the median nerve in the carpal tunnel are distinctive, and a simple surgical procedure brings prompt and complete relief. Nevertheless, the diagnosis is often overlooked and long delayed causing months or years of discomfort for these patients. Undoubtedly this diagnosis would be considered more often if its variations in symptoms were better understood. On the other hand, other causes of pain and numbness of the hand and arm should be carefully considered in the differential diagnosis.

ABSTRACT: Although aspirin has been proven to be an excellent antipyretic agent, cases of sensitivity and intolerance occur. Mefenamic acid (PONSTEL tm) would appear to have a role as an established antipyretic in clinical pediatrics. Data has been presented to indicate that mefenamic acid has an antipyretic effect similar to aspirin and appears to be equally well tolerated and free of side effects.

A New Antipyretic Agent

BY CHARLES F. WEISS, M.D., F.A.A.P.
SCOTT T. HARRIS, M.D., F.A.A.P.

Introduction

Mefenamic acid (PONSTEL^tm^) is a new compound which has been demonstrated by animal laboratory studies to have anti-inflammatory, antipyretic, and analgesic activity. It is a non-steroid, peripherally acting anthranilic acid.[1] Thus, it is pharmacologically similar to aminopyrine and acetylsalicylic acid. Extensive clinical studies have been carried out comparing mefenamic acid to other compounds for the relief of mild to moderate pain.[2, 3]

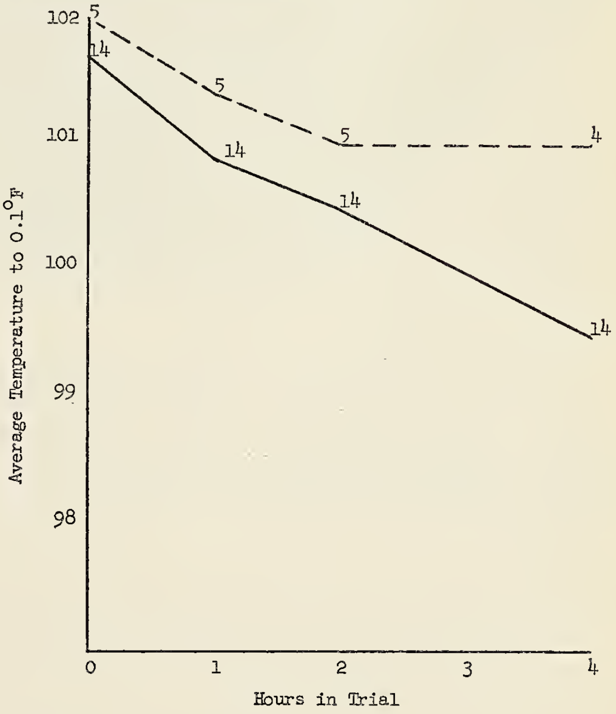
Compounds having antipyretic activity have obvious application to clinical pediatric practice. Aspirin is the most commonly used pediatric antipyretic in this country. In other parts of the world aminopyrine is commonly used. However, the use of aspirin is not without problems. It is not available in a suspension form. Occasional and varied hypersensitivity reactions and gastrointestinal bleeding are reported.

Pediatric clinical pharmacology studies of mefenamic acid were performer by the authors. These studies included blood level studies, 24-hour urinary throughput studies, and metabolic disposition evaluations. Such trials indicate that the metabolism of this compound in children is similar to that in adults.

After completing the pharmacology studies a trial was designed to evaluate the antipyretic ac-

TABLE I

Average temperature during the first day of medication for 15 patients by treatment group.



Legend:

——— Group A: PONSTEL tm*
– – – Group B: Acetylsalicylic Acid

(The number at each point is the number of observations used for that determination.)
*PONSTEL tm — trade name for mefenamic acid

Doctor Weiss is Associate Director, Clinical Therapeutics, Parke, Davis and Co., Ann Arbor, and Doctor Harris is Clinical Director, Plymouth State Home and Training School, Plymouth.

tivity of mefenamic acid. Evaluation of the analgetic activity was deferred in children since the results would need to be based on subjective observations. Furthermore, most pain-producing situations in children usually require some additional specific form of treatment. The antipyretic activity is an accurate objective measurement since concomitant treatment is often unnecessary.

Method

This study comparing the antipyretic effect of mefenamic acid with aspirin was performed on a group of institutionalized children. If patients were found to have a temperature elevation above 100°F, they were examined by a physician. If no cause for the temperature, which required some other form of treatment such as antibiotics, was found, those patients were included in the study. Each patient would then receive an initial dose of either mefenamic acid (6.5 mg/kg) or aspirin (in standard dosage) in a suspension form.

Temperatures were recorded one, two, and four hours after medication. The patient was dropped from the trial if definitive therapy such as antibiotics or antipyretic therapy such as sponging was employed.

Results

Patients ranged in age from 2 years, 2 months, to 8 years, 6 months. The weights ranged from 13 to 39 pounds. Mefenamic acid was given 26 times, and aspirin was given 19 times by random list to 30 patients participating in the trial. However, only the initial temperature response for the 30 patients is discussed here owing to the variable natural history of the disease. Eleven patients were excluded since they received concomitant antibiotics or other antipyretic measures.

Only 19 patients met the stringent requirements for inclusion.

The initial temperatures before medication ranged from 101°F. to 103.4°F. The acute disease entities included fevers of unknown origin, colds, neurogenic infectious bladders, and immunization reactions.

The average temperatures at each hour for the first 4 hours are plotted in Table I for the two medication groups. Paired t-testing indicates that the temperature drop is statistically significant at each hour for both treatment groups. The Chi-square test indicates no statistically significant difference between the two treatment groups. We can conclude that mefenamic acid is as effective as aspirin as an antipyretic agent. Close clinical supervision of these patients revealed that both products are accepted and well tolerated.

Conclusions

Although aspirin has been proven through the years to be an excellent antipyretic agent, cases of sensitivity and intolerance do occur. Aspirin is occasionally associated with gastrointestinal bleeding and increased capillary permeability. [4, 5]

In light of the above, mefenamic acid would appear to have a role as an established antipyretic in clinical pediatrics. It has an added advantage over aspirin being in the suspension form.

Data have been presented to indicate that mefenamic acid has an antipyretic effect similar to that of aspirin. Mefenamic acid appeared to be equally well tolerated and free of side effects.

Continuing studies will be performed to further evaluate the antipyretic effect as well as other activity.

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5. Lane, pp. 333-336.

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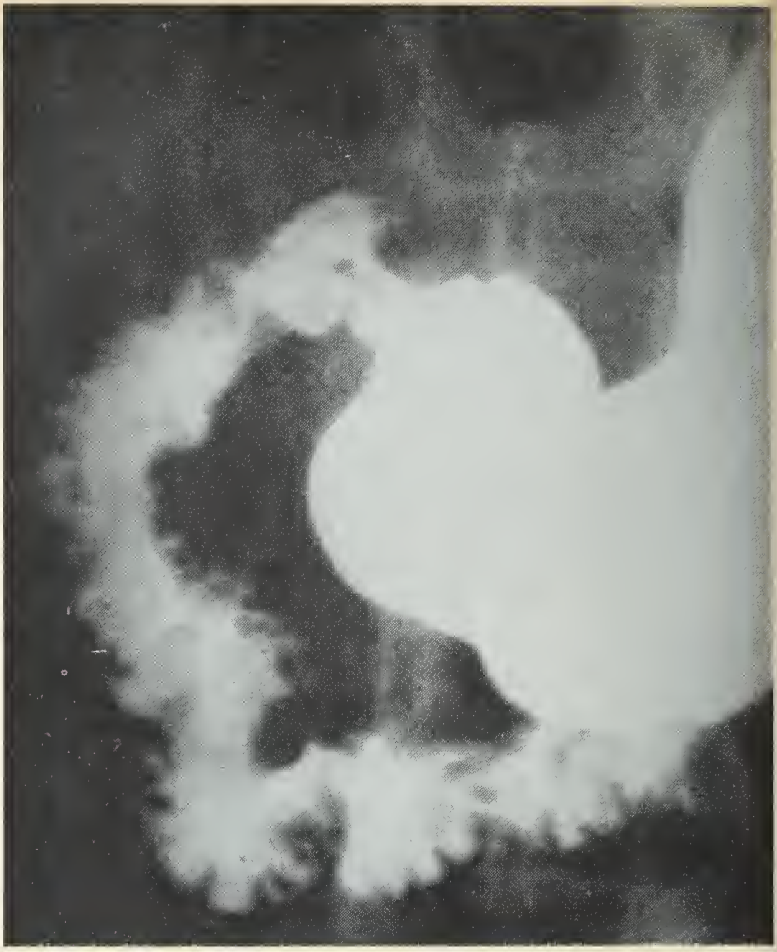

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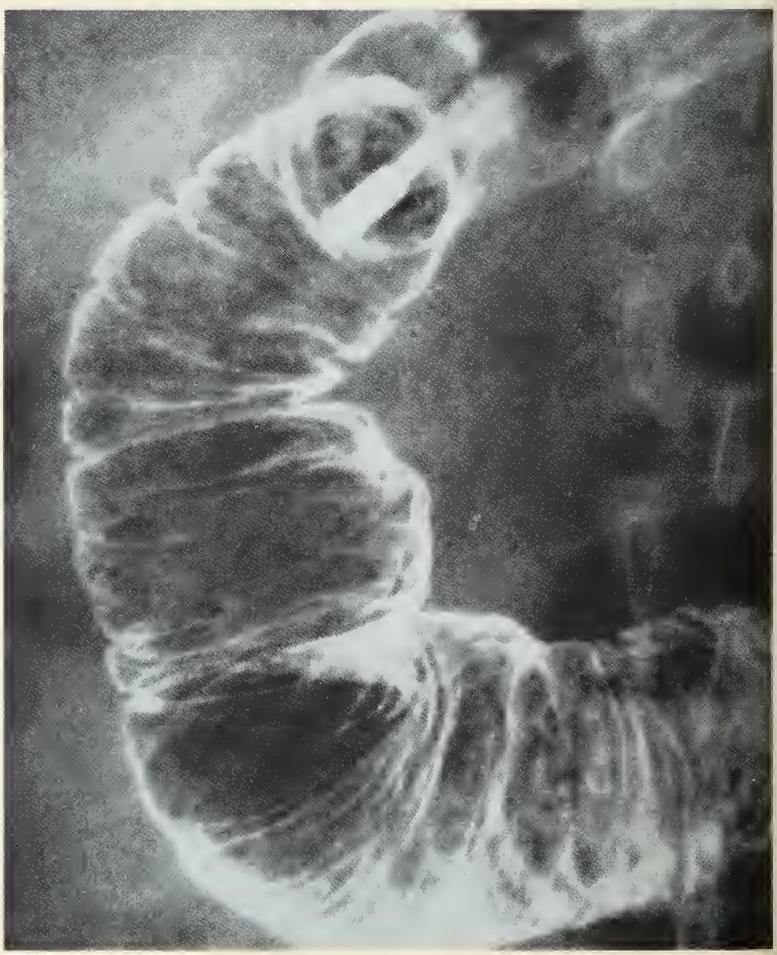

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Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

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(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27—Dec. 2, 1966.

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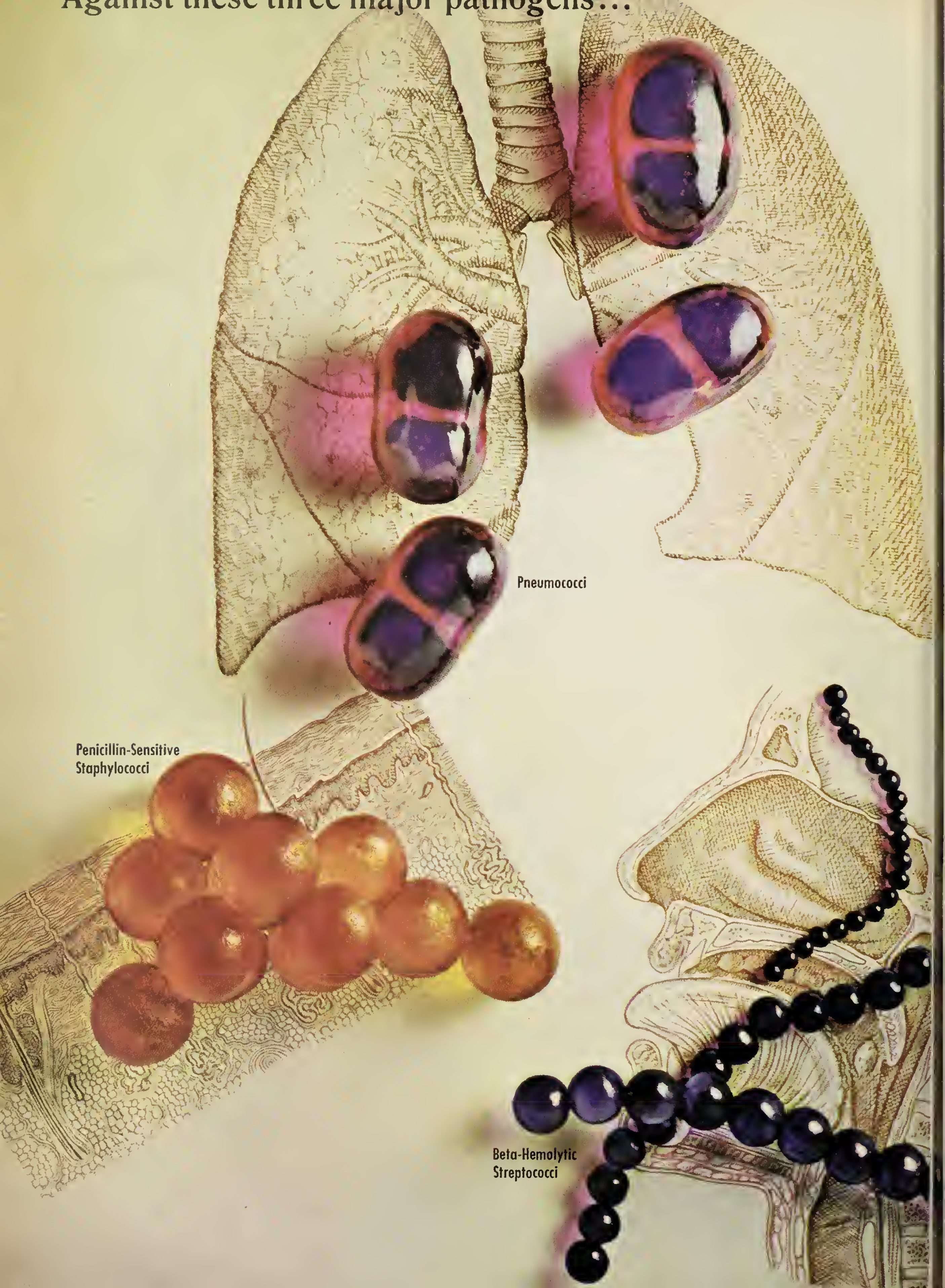
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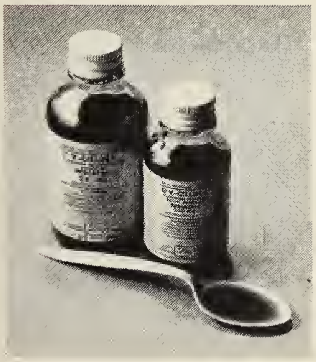

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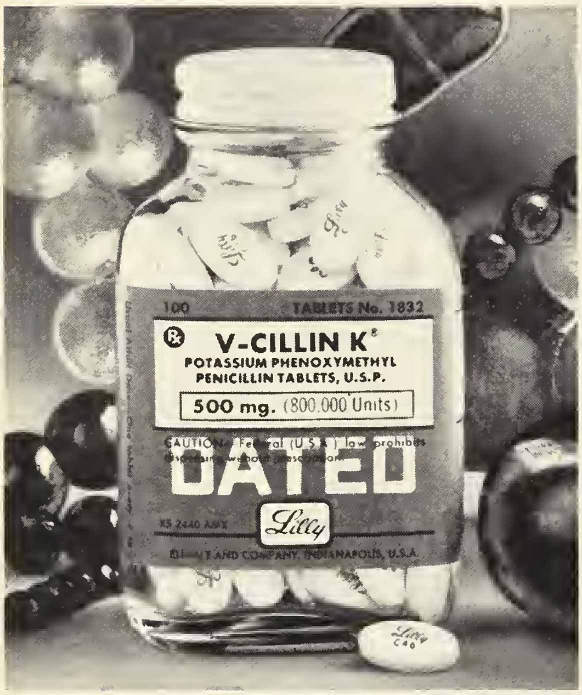
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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

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THREE BASIC ACTIVITIES PROPOSED

Michigan Health Information Research Institute Established

BY HERBERT A. AUER
MANAGING EDITOR

The establishment of a pace-setting Michigan Health Information Research Institute was approved by the Michigan State Medical Society House of Delegates at its 1967 Annual Meeting.

The independent institute will be established "to obtain, correlate and report upon research in the distribution of health care."

Action by the Delegates was based on two documents developed by MSMS Research and Development.

The first was "Where We Stand," the second "Information re a Health Information Research Institute."

MSMS Executive Director Brenneman had reported from time to time to The Council about research possibilities related to the health needs of the public and distribution of health care by the medical profession.

THESE AND OTHER CONCEPTS were included in a workbook, entitled "Where We Stand," which was reviewed by the Advisory Committee to the Executive Director and submitted to The Council. The Council in turn directed that the publication be mailed to members of the MSMS House of Delegates prior to the 1967 Annual Session.

The second document outlined the major structure and operational divisions of the proposed Institute.

The principles of an independent research institute, as outlined in the two documents, were endorsed by the 1967 House of Delegates. The House also instructed The MSMS Council "to provide for organizational expenses incidental to incorporation of the Institute . . . and to provide such seed money as The Council deems necessary and available within the limitations of its present overall budget." The delegates also authorized the Council to develop the materials necessary to present the principles of the Institute to prospective donors. (The major costs, according to current plans, will be borne by contributions from foundations and firms plus the receipts of payments from services rendered.)

THE RESOLUTION CREATING the Institute noted that "there is a need for factual data on medicine today"; and that already such "factual data are being accumulated by industry, labor, unions, universities and government," but it is not in such shape, form and availability as to be useful to policy-makers of medicine.

The resolution was introduced by Oakland Delegate Edward E. Elder, Jr.

The Institute will be devoted to research, education, training and publication in the following areas as they relate to the distribution of medical and health care:

- Economics
- Education
- Personnel Qualifications
- Ethics
- Government
- International Relations
- Communications
- Hospital and Institutional Relations
- Physical and Social Sciences

The Institute also "will seek to advance knowledge, help develop an informed opinion among members of the health professions, as well as persons and organizations related thereto. Further, it

Continued on 1440

would encourage the effective, ethical and economical administration of medical and health affairs."

Three Basic Activities

THE INSTITUTE, according to Robert J. Mason, M.D., Chairman of The Council and elaborated by Mr. Brenneman, would have three basic activities. They are: 1 - The pursuit of facts and opinions; 2 - The processing and the packaging of these facts and opinions; and 3 - The dynamic distribution of the product.

1) *The pursuit of facts and opinions*: The *full* extent of the research now being carried on in areas which have to do with the distribution of health care is not known by any one man or organization. It is known that monies expended annually in such research equal many millions. A primary objective of the Institute would be to seek out, analyze, authenticate, correlate and report existing research and relate these studies to Medicine's objectives.

A second service would be to reveal areas in need of research and invite these to the attention of those organizations and groups who conduct original research programs. This would, of necessity, involve the continuing evaluation of existing data.

2) *The processing and the packaging of the facts and opinions obtained*: Policy making boards of directors who are making decisions on the distribution of health care are made up of men having widely diverse backgrounds. Relatively few are statisticians or actuaries. Thus the fruits of today's research are often denied these boards because the reports are too voluminous, too abstract, too expensive to obtain and analyze, too incomplete, etc. A service of the Institute would be to establish means of processing research results so that they would be inexpensively and easily available. Just as products in the supermarket are packaged so that they can be instantly recognized and understood, so should this Institute package the facts and opinions which have been obtained in responsible research so that this information would be fascinating and easily accessible to those who would use it.

Further, it's well known that ofttimes there is a great wealth of fact and opinion which can be obtained from data accumulated in the course of research which the original sponsor of that research had no use for. This "spin-off information" can be of great value when related to other research and other problems. The Institute would serve as such a clearing house.

3) *The dynamic distribution of the product*: Facts and opinions collected through authentic research should be invited to the attention of those who can use them at arriving at policy determinations. Yet all too often, research reports gather dust in the archives of organizations which cannot make use of the full significance of the facts obtained. The Institute should carry out an ubiquitous merchandising of information it finds available to those members of the health professions and others who can make maximum use of these facts in the public interest. Pasteur said: "Fortune favors the informed mind," and judgments in health affecting the lives of millions of Americans and involving billions of dollars, can be better made if the responsible persons are factually informed with information upon which they can fully rely.

Also, as has been done in other areas, e.g. industry, labor, farming, etc., the establishment of such a clearing house has proven of remarkable value to those segments of society when used by legislative bodies and governmental administrative agencies.

EARLY DISCUSSION by MSMS officers, councilors and delegates quickly indicate that the Institute is a complex proposal with many ramifications. It has been recognized too that the Research Institute has potential significance far in excess of the apparent simplicity of the original charge.

Already there has been a thorough study of the literature, interviews with many leaders of medicine and opinion molders, and a selection of materials from state and national reports covering the entire range of concerns of MSMS.

As the MSMS staff has researched the need for research this in itself became a formidable task.

Workbook Published

THE WORKBOOK, ENTITLED *"Where We Stand,"* has been described as "an analytical overview of some of the current concerns and activities of MSMS and related, emerging, unanswered questions."

In addition to serving as the executive director of MSMS, Hugh W. Brenneman has assumed responsibility to explore the area of MSMS Research and Development. This new booklet is the first by MSMS in this field.

Material for the booklet was divided into 13 subject areas. Under each subject, the author, Mr. Brenneman discusses the subject and follows it with questions. The booklet points out these questions need some answers, "some in the very near future."

In part, the booklet states:

"The Michigan State Medical Society should pause at this moment in time to see where it has been, where it is today, and where and how it will challenge the future; for, in the future, groups (as contrasted with individuals) will be dominant. The very real question is how the individual will be effective and maintain self-identity."

Tells Why Research

Introductory comments point out the need for MSMS to seek out more facts through research. In part:

". . . the complexities of today's social, political, and economic societies indicate the desirability of using the best tools extant for the rooting out, evolving and resolution of reliable information. In this way the combined wisdom of doctors of medicine can be supplemented and buttressed in the decision-making process by current, extensive knowledge and detailed truth."

DIFFICULTIES IN establishing priorities for MSMS study and action are discussed in the booklet.

In part the publication states:

"A thoroughly researched effort must be made if the development of priorities is to prove a practical guide. Factors of personnel, finances, politics, and time — not to mention other hurdles — must be taken into account. Hardheaded decisions must be made, consistent with the practicalities involved as well as the hoped-for accomplishments.

"Under the system presently used, policies evolve rather than originate. They appear as a reaction to challenges. Beginning with a component county society, an MSMS committee, individual members, or staff, a policy or project flows through a sieve of group thinking in a democratic process. While this is highly desirable in the development of major policy, it has three weaknesses:

A. It does not anticipate problems or permit advance research of facts and opinions which would be valuable in the decision-making process.

B. Of necessity, the democratic process is slow-moving, and medicine is vulnerable in the interim between the time the need is originally envisioned and the date of final policy adoption. Medicine's enemies know of this weakness and capitalize upon it.

C. The best timing for the implementation of this organization's desires sometimes depends upon unforeseeable events and actions of persons outside medicine. Many times the implementation of medicine's desires could be more efficacious if reliable facts and authentic opinions were quickly available.

"The questions inevitably arise:

1. Where can Michigan medicine obtain a rapid and reliable *determination of physician and public opinion?*
2. Where can Michigan medicine reliably obtain from time to time the particular *compendium of facts* necessary for proper evaluation of any major problem and expect those facts to be prepared in a fashion that permits easy and quick review of their significance?
3. Is it possible for a Research and Development group working on a permanent basis to foresee trends in the distribution of medical care and invite attention to emerging problems, thus permitting competent advance and long-range planning?

"Answers to the above are important only if problems (sufficient in number, importance, and magnitude) face the profession and demand solution."

The booklet covers 13 subject areas:

Science
Medical Education
Ethics, Discipline, Professional Qualifications, Standards, and Morals
Legislation, Forensic Medicine, Laws and Regulations Governing Practice
Economics, Organization, and Business Problems of Private Practice
Communications and Public Relations
Civic and Community Affairs
National and International Affairs
Governmental Medicine
Sociological Medicine
Occupational and Institutional Relationships
Organization
Research and Development

Each of these areas will be covered in future issues of *Michigan Medicine,* official journal of the Michigan State Medical Society.

Continued on 1442

IN THIS BRIEF INTRODUCTORY article, one or two of the provocative questions raised in the publication for each area will follow. Which of the many questions to select is a formidable task. The ones selected, it is hoped, will trigger many others in the minds of the MD readers:

SCIENCE

What will be the effect of the electronic revolution on patient care?

What effect will automation have upon the interrelationship and interdependency of physicians?

MEDICAL EDUCATION

How can increased emphasis be given to the education of guidance counselors in the field of medicine and health?

Can methods be developed to provide a continuous overview of medical service trends so that educational patterns can be cut to meet the practical needs of the future?

ETHICS

Should the MSMS Judicial Commission be asked to inaugurate (perhaps in cooperation with the Medicine and Religion Committee) an exhaustive study of the "nature and scope of new moral responsibilities of the medical profession" caused by rapidly advancing scientific and engineering knowledge, increasing population, e.g.,

1. Moral questions involved in altering the DNA pattern, such as changing of personality, physical attributes, etc.?
2. Moral questions involved in population control?
3. Moral questions involved in limited supply of lifesaving machinery and facilities?
4. Moral questions involved in artificial insemination using frozen sperm?
5. Moral questions involved in abortion?

LEGISLATION

Should medical expert panels be supplied by MSMS for:

1. Malpractice cases?
2. Workmen's Compensation cases?
3. As a service to the court when it is unable to obtain satisfaction in cases of disputed medical testimony?

Should MSMS conduct a teaching program at its headquarters, recruiting as students key members of government including the members of the Legislature—such a teaching program to cover in some depth the medical subjects where controversy is keenest, e.g., the eye, x-ray, orthopedics?

ECONOMICS

What would be the effect on the solo practice of medicine rendered on a fee-for-service basis if comprehensive programs providing a broad spectrum of services become more available?

What effect is the disappearance of medical indigence having upon

1. The income of the physician?
2. His patterns of charging for services?
3. His relationships with his patients?

COMMUNICATIONS

Should a random sampling survey system be developed which could be used economically and at semi-monthly intervals to provide a continuing study of medical opinion of AMA and MSMS projects?

How efficacious would be a video tape system (tapes made nationally, state, and locally with statewide distribution and a headquarters library) in serving the purpose of communicating medical society programs and policies as well as scientific information?

CIVIC AFFAIRS

Should a study be made of the role MSMS should play in resolving the Negro problems?

Should a study be made of the probable effect the civil rights movement will have upon medical practice in Michigan?

NATIONAL, INTERNATIONAL AFFAIRS

What part should MSMS play in the medical care of the people of any foreign nation? Belize, as Michigan Partner in Partners of the Alliance for Progress?

Should MSMS take an active role in national relationships with such organized efforts as the Partners of the Alliance, Project HOPE Ship, AMA international physician placement service, etc.?

GOVERNMENTAL MEDICINE

What will be the effect on the medical profession of an increasing percentage of the gross amount spent for medical care being contributed by the governmental sector?

What voids in preventive health exist that might encourage governmental programs to proliferate further?

SOCIOLOGICAL MEDICINE

What effect will there be on medical practice when most people believe that access to high-quality medical care is a right to which every American citizen is entitled?

What will be the effect on the practice of medicine of consumers concerning themselves more and more with the quality of medical and health care?

OCCUPATIONAL AND INSTITUTE RELATIONSHIPS

Can more efficient organization and integration of paramedical and professional medical personnel be obtained? If so, would it have an effect upon the availability, cost, quality and/or distribution of medical care?

How can physicians and their organizations become more closely associated with hospitals' boards of trustees?

ORGANIZATION

Should a survey be made of MDs who are not members of MSMS to determine why they are not, so that appropriate action might be taken to subsequently attract them to join if their membership is desired?

How can the work of those MSMS and component society committees having similar purposes be better coordinated?

RESEARCH AND DEVELOPMENT

What mechanism has the MSMS for explaining the relationship between medicine and society and examining the joint problems, issues, and developments involved in the supplying and receipt of medical care?

Is the medical profession unaware of, or indifferent to, the many social, political, and economic changes of our society?

Is the MSMS tending to move too slowly in response to public demands for change?

How can MSMS continuously, and with assurance of reliability, determine the demands and needs for medical care among the public and its various segments?

MANY TIMES THE PUBLICATION stresses the need for more facts to help MSMS study and solve challenges and problems.

One of the statements that vividly supports the need for research is this one:

"Only the medical profession through its collective voice should determine its methods of practice — i.e., the distribution of health care."

Future articles in *Michigan Medicine* will quote further from the new MSMS working document.

Watch for them!

Major Programs Explained

Many Michigan Physicians Volunteer To Assist Other Countries

BY PETER HOHEISEL
OF THE MSMS STAFF

Many Michigan doctors have volunteered and continue to contribute their medical skills to help other nations.

The International Health Committee of the Michigan State Medical Society seeks to encourage Michigan doctors of medicine to consider such medical service; and the Committee also studies various questions and presents recommendations.

* * *

"Volunteer Physicians For Viet Nam"

While the military side of activity in Viet Nam receives the most public attention, there is another war going on in Viet Nam: that is the war against injury, disease, and any other evil which prevents the health and social development of the South Vietnamese people.

For some time now, many Michigan physicians have been giving of their medical skill to the civilian population of Viet Nam.

The AMA currently is sponsoring a program called the "Volunteer Physicians for Viet Nam," which sends American doctors for a two-month period to work with Vietnamese civilians. The program is financed by the United States Agency for International Development and administered by the AMA.

The volunteer physician receives a ten dollar a day living expense, plus travel expense to and from Viet Nam. He works in one of the 16 provincial hospitals in which Vietnamese civilians are treated.

The program grew out of a request from the South Vietnamese government to help fill the gap caused by recruitment of Vietnamese doctors into the military. Of Viet Nam's 1,000 doctors, 650 are working with the military, leaving only 350 to care for 15 million South Vietnamese civilians.

Michigan physicians who have served in Viet Nam under the AMA program are:

Robert F. Baugh, M.D., Detroit
Edward S. Bear, M.D., Detroit
Hugh T. Caumartin, M.D., Saginaw
Lambertus Mulder, M.D., Muskegon
Hugh L. Sulfridge, M.D., Saginaw
Franklin W. Wade, M.D., Flint
Joseph A. Grady, M.D., Detroit
A. J. Neerken, M.D., Kalamazoo

Many other Michigan doctors (the list is incomplete) have served in Viet Nam through other overseas aid programs.

The words of Robert F. Baugh, M.D., of Detroit, who has served in the program illustrate the problem: "You get a sense of being overwhelmed by the tremendous medical need when you are over there. Viet Nam could absorb as many doctors as we could send."

"All the medical institutions have been built," he continued, "with the idea that they will be taken over by Vietnamese when we leave."

Charles H. Moseley, director of the AMA program, explains that when the American doctor arrives in Viet Nam everyone soon finds out "who he is, what time he gets up, almost everything he does."

"This program has done more to improve the image of the American physician," Doctor Moseley continued, "than any I know of. The Vietnamese people know that a physician who closes his office and comes as a volunteer to their land is making a sacrifice for them." He continued:

"This program is outstanding because it is winning the friendship of the Vietnamese people. In many ways it is helping win the war because the Viet Cong knows that if anything happens to him or his family, he will be treated in the provincial hospitals."

The International Health Committee of the Michigan State Medical Society is so convinced of the effectiveness of medical aid in helping win the Vietnamese war that it has recently passed a resolution asking that the United States increase its budget for medical aid to South Vietnamese civilians. The MSMS Council approved the Committee recommendation.

As Hira E. Branch, M.D., of Flint, Chairman of the International Health Committee pointed out in an editorial in *Michigan Medicine,* "The total medical budget, everything from bricks and mortar to vaccines, is .02 percent of the total United States spending in Viet Nam for 1967." The present budget, Doctor Branch explained, is fifty million dollars; if only 1 percent of the budget were spent on civilian medical care, it would have to be increased to $250 million. "Even this would not be nearly enough," he said.

Project Hope

Besides the AMA Viet Nam Project, there are many other organizations and missionary groups which sponsor American physicians in working overseas.

Many Michigan doctors have served, for example on the Project Hope Ship. (Two medical students have also served in the summer on the ship.)

The Hope Ship visits a country for 10 months to render active medical service and also train medical personnel in the country which is being visited.

Michigan has made the second largest contribution of medical personnel to the Hope Ship of any of the States. Only California has contributed more personnel to the Ship. Michigan contributed 31 doctors.

The physicians serve for a two-month period on the ship. Five teams of physicians are used, therefore, on every ten month tour.

Officials for the Hope Ship project report that Michigan physicians who have served on the Ship are:

Marshall Alcorn, M.D., Bay City — Guinea
Stewart Barden, M.D., Battle Creek — Ecuador
Robert Burns, M.D., Grosse Pte. — Guinea and Colombia
Clarence Chrest, M.D., Kalamazoo — Guinea
Harold Decker, M.D., Ann Arbor — Indonesia
Thomas Del Giorno, M.D., Grosse Pte. — Ecuador and Guinea
Howard Feigelson, M.D., Detroit — Peru
Harvey Gass, M.D., Detroit — Indonesia and Peru
Quentin Hamilton, M.D., Southfield — Nicaragua
William Hardy, Jr., M.D., Detroit — Nicaragua
Frank Hodges, M.D., Saginaw — Indonesia
Robert Knighton, M.D., Detroit — Peru
Edwin Knights, Jr., M.D., Bloomfield Hills — Indonesia and Ecuador
J. D. Langston, M.D., Grosse Pte. — Peru
Robert Lowry, M.D., Muskegon — Ecuador
Susan McCutcheon, M.D., Detroit — Guinea and Colombia
Robert Nixon, M.D., Detroit — Peru and Ecuador

Continued on 1446

Established 1924

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Conducted by Sisters of Mercy
Ann Arbor, Michigan
Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

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Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.

* 1904 - 1967

Thomas Parker, M.D., Hancock – Nicaragua
Charles Parkinson, M.D., – Battle Creek – Ecuador
John Rawling, M.D., Flint – Indonesia, Peru and Nicaragua
Charles Rogers, M.D., Bay City – Nicaragua
Charles Ryan, M.D., Battle Creek – Ecuador
Irvin Sander, M.D., Birmingham – Guinea
Irwin Schatz, M.D., Detroit – Ecuador and Guinea
Donald Simmons, M.D., Detroit – Indonesia and Peru
James Taren, M.D., Ann Arbor – Peru, Ecuador and Guinea
Malcolm Young, M.D., Muskegon – Peru and Ecuador
Raymond Monto, M.D., Lathrup Village – Colombia
Jose Bebin, M.D., Detroit – Colombia
Charles Wright, M.D., Detroit – Colombia
John Goodsell, M.D., Saginaw – Colombia

Medico

Another organization which has sponsored Michigan physicians serving overseas is MEDICO, which is administered by CARE.

Michigan physicians who have served through MEDICO are:

Robert G. Axelrod, M.D., Oak Park – Afghanistan
Leland L. Swenson, M.D., Muskegon – Nigeria
Joseph Weiss, M.D., Detroit – Afghanistan
Alfred B. Swanson, M.D., Grand Rapids – South Viet Nam
Robert G. Braden, M.D., Grosse Pte. – Malaysia
Hira E. Branch, M.D., Flint – South Viet Nam

* * *

The above lists certainly are not complete. Another list, perhaps longer, would include the many physicians who have gone to other nations under church sponsorship. The doctors report that medical missionary work is very rewarding.

MEDICAL MEMO

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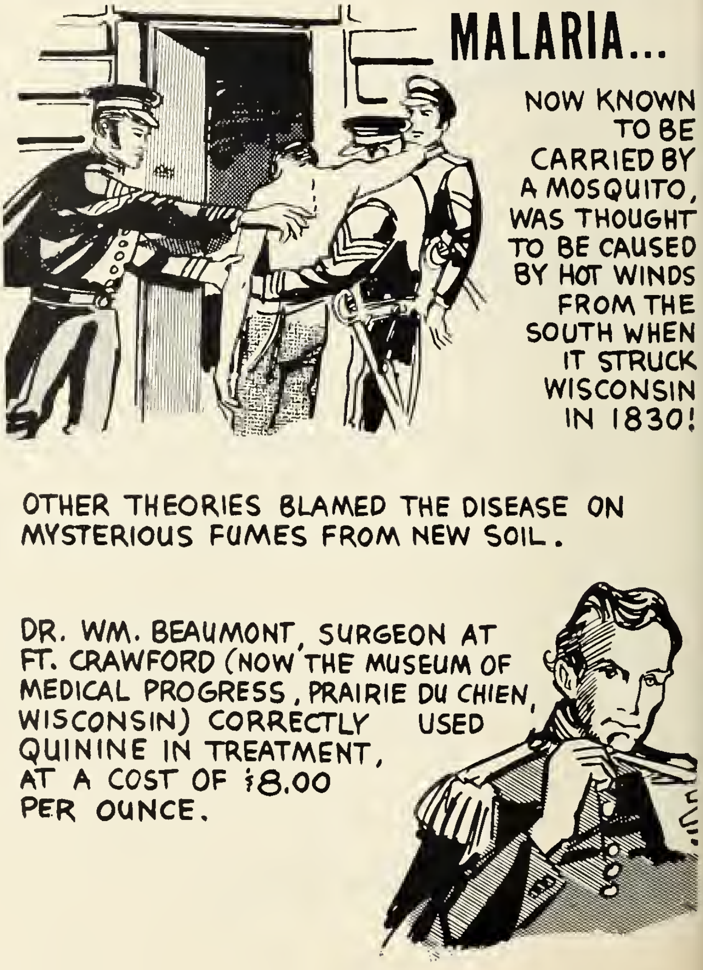

MALARIA... NOW KNOWN TO BE CARRIED BY A MOSQUITO, WAS THOUGHT TO BE CAUSED BY HOT WINDS FROM THE SOUTH WHEN IT STRUCK WISCONSIN IN 1830!

OTHER THEORIES BLAMED THE DISEASE ON MYSTERIOUS FUMES FROM NEW SOIL.

DR. WM. BEAUMONT, SURGEON AT FT. CRAWFORD (NOW THE MUSEUM OF MEDICAL PROGRESS, PRAIRIE DU CHIEN, WISCONSIN) CORRECTLY USED QUININE IN TREATMENT, AT A COST OF $8.00 PER OUNCE.

Night Leg Cramps... Unwelcome Bedfellow
In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]

now ... specific therapy for night leg cramps

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QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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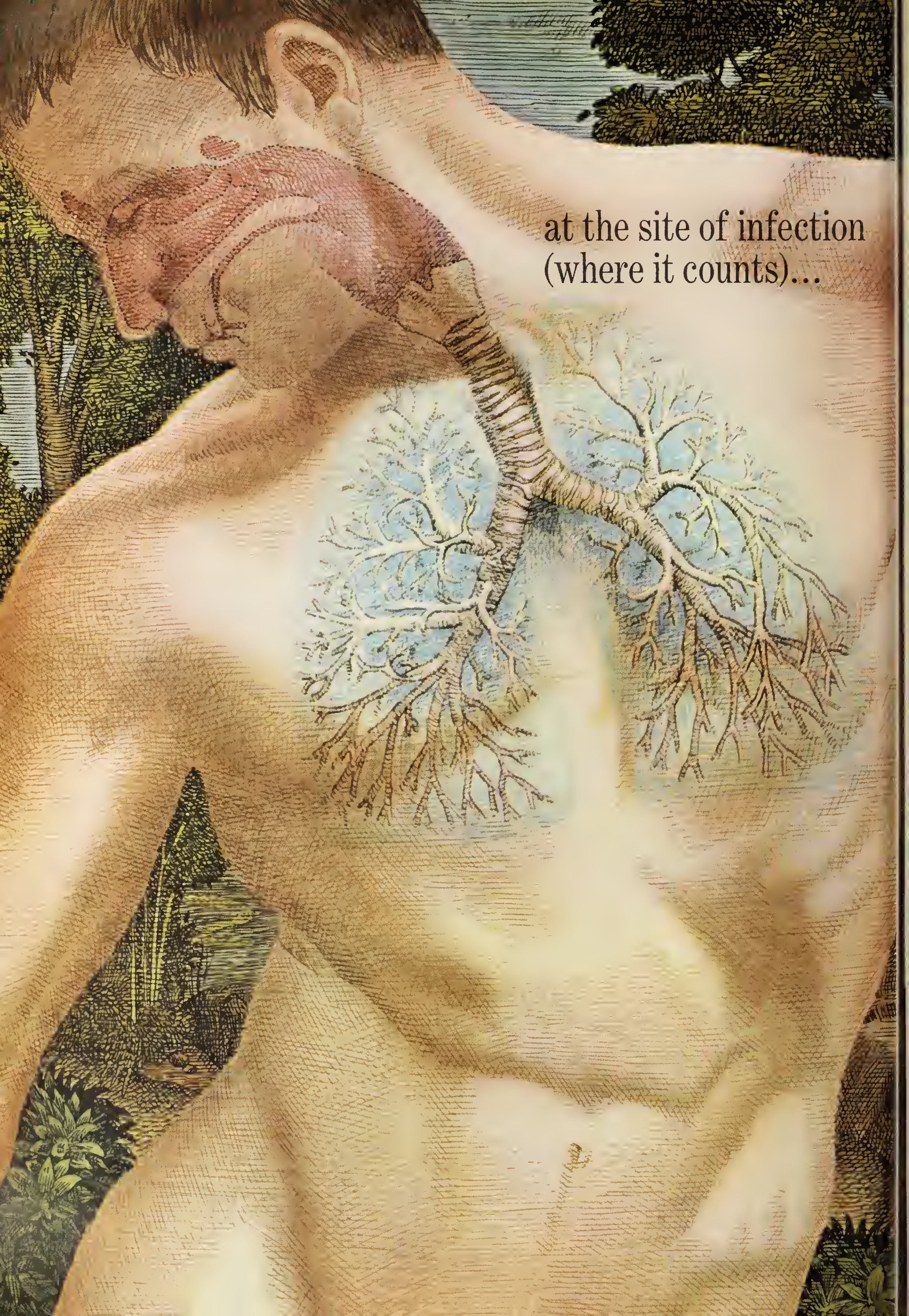
Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

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Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by micro-organisms sensitive to its action—especially staphylococci, hemolytic streptococci, and pneumococci.

It has been effective in streptococcus infections, particularly acute bacterial pharyngitis and tonsillitis; staphylococcus disease, including soft-tissue infections, furunculosis, abscesses, cellulitis, carbuncles, and wound infections; pneumococcus pneumonia and acute bronchitis with pneumococci on culture, bronchopneumonia, and otitis media.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents; surgical procedures should be performed when indicated, and large doses of the antimicrobial agents should be employed.

Penicillin is the drug of choice for syphilis and gonorrhea, but Ilosone in multiple 500-mg. doses has been useful in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Known history of sensitivity to this drug; preexisting liver disease or dysfunction.

Adverse Reactions: Hepatic dysfunction with or without clinical jaundice has been reported infrequently. Changes in liver function tests indicative of intrahepatic cholestasis appear to be the result of individual idiosyncrasy. Findings subsided when treatment was discontinued. Occasionally, symptoms simulated extrahepatic obstructive jaundice or the colic of biliary tract disease.

When jaundice appeared to be related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Gastro-intestinal disturbances not associated with hepatic effects and occasional allergic manifestations (urticaria, skin eruptions, and, rarely, anaphylaxis) have been reported. The normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Administration and Dosage: Ilosone is administered orally.

Infants and children under twenty-five pounds, 5 mg. per pound every six hours; twenty-five to fifty pounds, 125 mg. every six hours. Adults and children over fifty pounds, 250 mg. every six hours.

For severe infections, double the dosage. When larger doses are indicated, consider parenteral erythromycin therapy. In beta-hemolytic streptococcus infections, maintain treatment for ten days to prevent rheumatic fever or glomerulonephritis.

In syphilis, a total of 20 to 30 Gm. is administered in divided doses for ten to fifteen days. Close follow-up is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examination of spinal fluid is recommended during follow-up.

In gonorrhea, the dosage is 500 mg. four times a day for four days. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics and monthly serologic tests for three months. For detailed information, consult the package literature.

How Supplied: Pulvules® Ilosone, Capsules, N.F., 125 mg.* and 250 mg.*

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg.* per 5-cc. teaspoonful.

Ilosone, 125, for Oral Suspension, N.F., 125 mg.* per 5-cc. teaspoonful.

Ilosone Drops, 5 mg.* per drop.

Tablets Ilosone Chewable, N.F., 125 mg.*

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*Base equivalent. [080967]

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247:*69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12:*398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239:*198, 1960.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

701464

Doctor, How Can MARMP Be of Greatest Value to You?

BY DON MARSHALL, M.D.
MSMS REPRESENTATIVE TO MARMP

In the fields of heart disease, cancer and stroke, how can MARMP work everywhere in the state to improve the ability of the health team and care of the patient?

The Michigan Association for Regional Medical Programs (MARMP) is moving into operation now after much preliminary planning.

Every physician, county society and hospital staff is urged to submit suggestions at any time on ways in which the MARMP program in Michigan can be of value to them. The State of Michigan is a region under the Heart-Cancer-Stroke Bill, officially known as PL 89-239. It was signed by President Johnson on October 6, 1965.

TO HANDLE PL 89-239 in Michigan a state corporation has been formed, The Michigan Association for Regional Medical Programs, or MARMP. On its corporate body are representatives of six subdivisions of the state, the public, dental and nursing professions, heart and cancer groups, the Michigan Department of Public Health and the three medical schools. This corporate group of 22 has a Board of Directors, Bylaws, officers, and holds regular meetings, the whole group three or four times a year, and the Board of Directors twice a month.

The Corporation has made application and received a first-year planning grant of $1,285,155. Of this, $161,781 will be utilized for a Central Executive Office in Lansing, headed now by Albert E. Heustis, M.D., recently resigned as Commissioner of the Michigan Department of Public Health.

Based on applications approved first by the corporation, the rest of the initial grant will go to the three medical schools and the Department of Public Health. In the next several months it is anticipated that applications will be received from some of the six sub-regions and other groups. The initial projects are only the beginning, and at this time mostly in a planning stage; they do not indicate at all the ultimate or potential extent of activities under this program.

The initial four approved projects, as defined to this time, are as follows:

University of Michigan

The University of Michigan has established a Central Secretariat to coordinate the University's activities in the regional program with other participants of the corporation.

The U of M is also planning the development of educational programs in cancer chemotherapy through its program of post-graduate education for physicians throughout the region. This project will make available to district planners the University personnel involved to assist in the development of cancer chemotherapy projects within state districts.

The School of Nursing at the University of Michigan is planning the development of a post-graduate education program to update nursing practices in relation to heart disease, cancer, and stroke.

Another project being planned by the University of Michigan, especially its College of Pharmacy, is the development of a drug information therapy analysis and reporting system. This project intends to provide to health personnel in the region:

1. Information on present drug usage;
2. Analysis of present and future drug therapy patterns;
3. Information to physicians through a drug information abstract service.

A project providing for the greater utilization of non-professional staff in the treatment of patients with heart disease, cancer, stroke and related diseases is being planned by the University of Michigan. Based at Wayne County General Hospital, this project will scrutinize non-professional health services and resources within the state to determine what steps will best provide comprehensive

Continued on 1454

Sustained circulatory, respirator
and cerebral stimulation for th

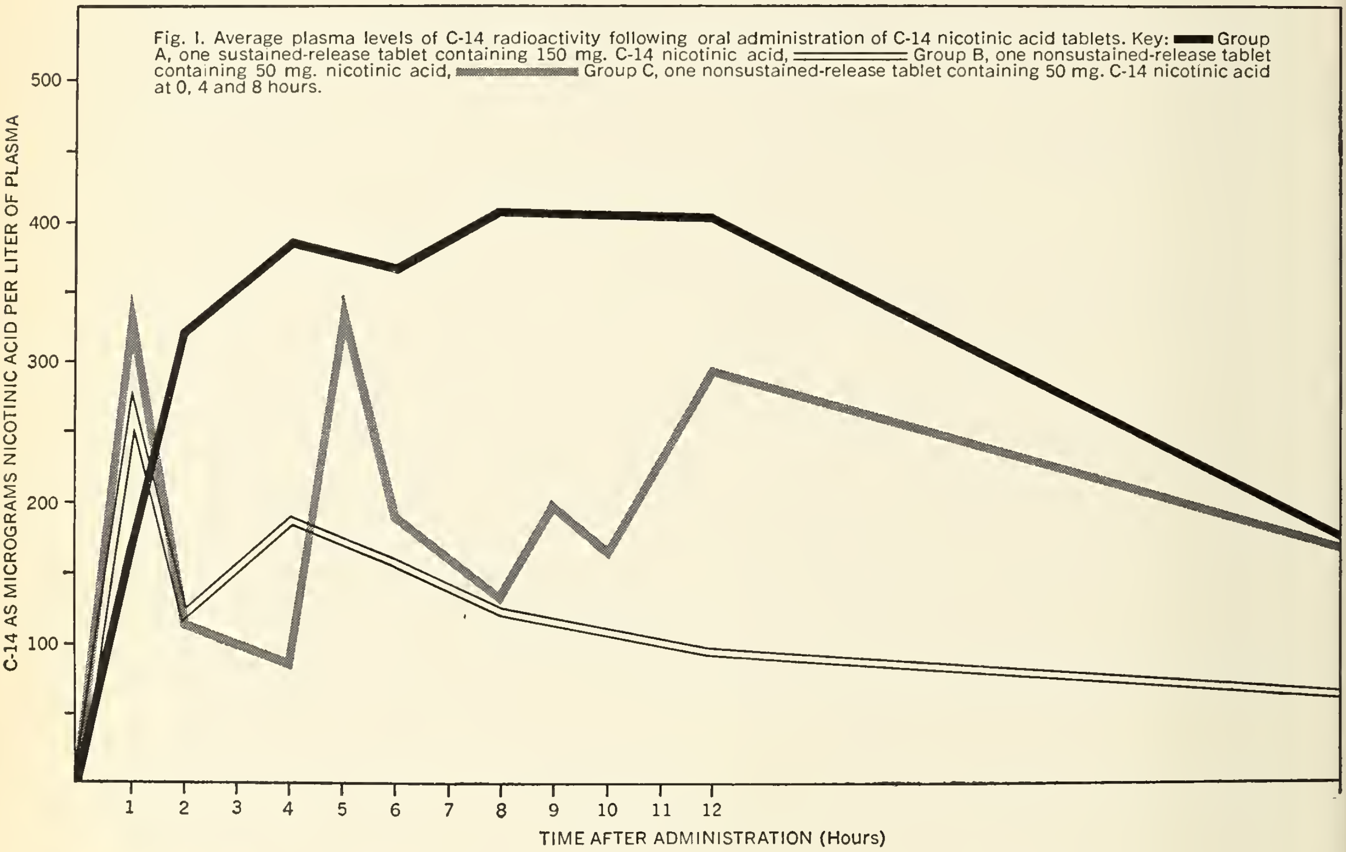

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

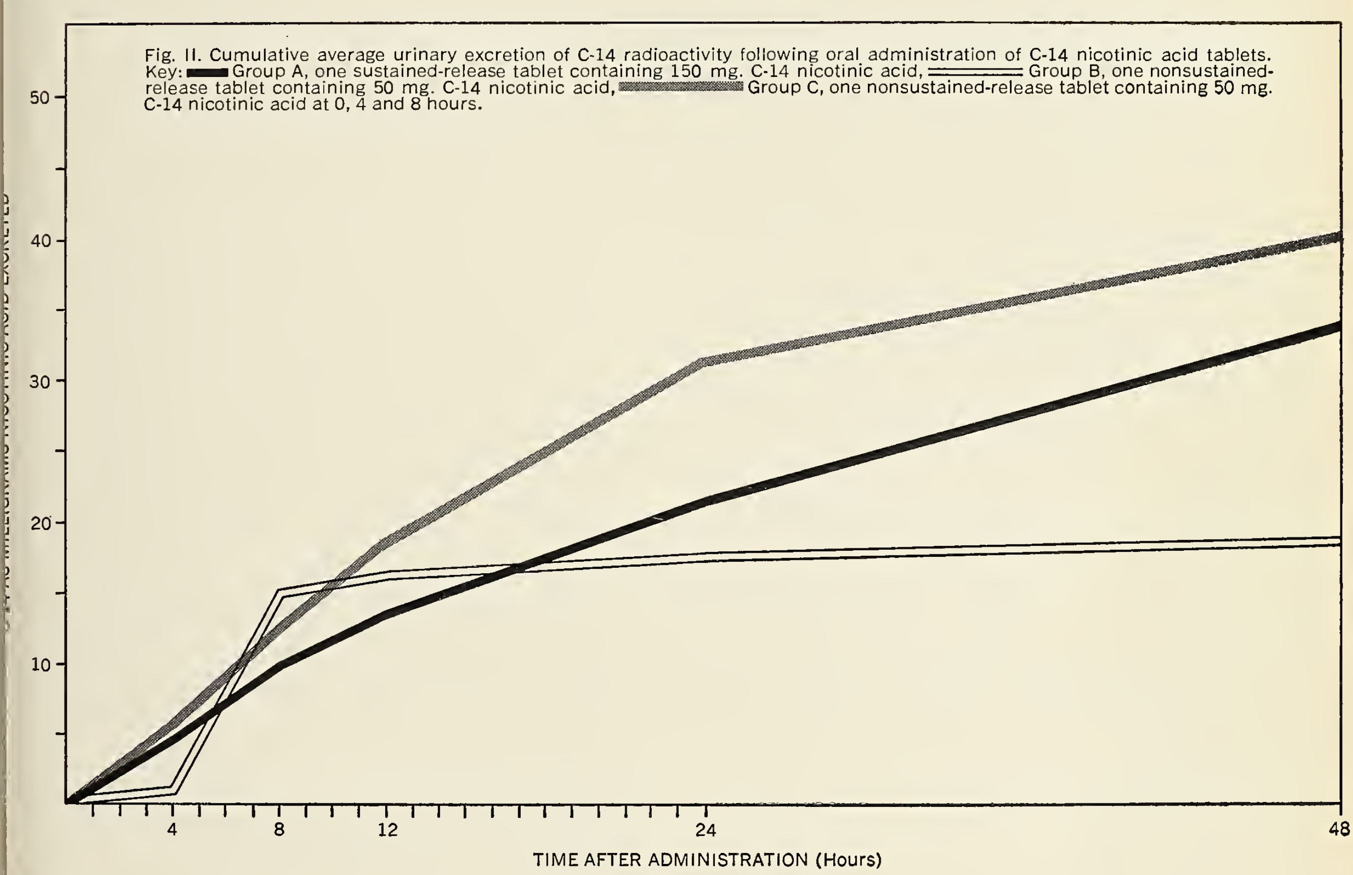

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ess confused and moody. Personal care, memory, motional stability, social attention improve. Fatigue, pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

ontraindications: There are no known contraindications.

recautions: Exercise caution when treating patients vith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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training of technical and other service workers to better care for patients with heart disease, cancer, and stroke.

Wayne State University

Wayne State University is developing a comprehensive program for the Detroit Metropolitan Area involving professional education, demographic information, use of services and resources, and communication and information systems.

Michigan State University

Michigan State University, which is in the preliminary stages of formulating a "medical center" arrangement in the Greater Lansing and Tri-County area, will examine the processes and methods by which health care facilities and services are coordinated in a geographically defined area. MSU will also study and prepare for the application of the University's significant resources for continuing education utilizing decentralized centers and extension concepts.

State Dept. of Public Health

1. The Michigan Department of Public Health will use its Center for Health Statistics in order to carry out an ongoing state-wide health survey to sample the population with respect to such information as:
   a. Number of persons with known diagnosis of disability resulting from heart disease, cancer, stroke, and related diseases
   b. Extent to which persons are under care
   c. Attitudes
   d. Assessment of disability and asymptomatic disease through screening and examination

THE PURPOSE of PL 89-239, briefly, is to improve the diagnosis and care of patients who have heart disease, cancer, or stroke, by promoting cooperation among all health agencies and personnel. The law desires to improve generally the nation's health manpower and facilities, without interfering with the patterns or financing of patient care or professional practice. The law demands cooperation among all groups concerned, and it demands initiative from the grass roots up. The essential test of the program lies in the ability of the groups concerned to establish and implement voluntary cooperative arrangements to gain their objectives. At the federal level the law is administered by the National Institutes of Health, under the guidance of a National Advisory Council, of which James T. Howell, M.D., of Henry Ford Hospital, is a member.

AMA SELLS BOOK ABOUT NUTRITION

The housewife and her hungry family usually are not nutrition authorities, but they do frequent have questions about food that they wish an expert would answer.

A book of authoritative answers to just such questions has now been published by the American Medical Association.

"Let's Talk About Food," is a collection of the best questions and answers that have appeared in the monthly column of the same title in *Today's Health* magazine. Discussions range from nutrition concepts, food composition, food storage and preparation to the use of chemicals in food processing.

Questions are submitted by readers of the magazine. Answers are made by Philip L. White, Sc.D., director, AMA Department of Foods and Nutrition. Dr. White also edited the book.

The AMA's purpose in publishing the book is stated in the foreword:

"Food does more than satisfy hunger and provide pleasure, it also helps man to reach his genetic potential. The health and well-being of the people of the world now and in the future depend upon how efficiently man develops, protects and uses his food supply. Unfortunately, the gap between the world's population and its food supply is widening; therefore, every person now alive has a responsibility to make good use of today's food supply to prevent further widening of this gap."

Misinformation about food, distributed by faddists, unscrupulous marketers, and others, is one of the greatest deterrents to proper use of food, Dr. White points out.

"Let's Talk About Food" does not attempt to refute the many misleading claims, but offers instead positive and authoritative information which can be used by the reader in evaluating various claims.

"It is the AMA's opinion," writes Dr. White, "that the well-informed consumer will not be duped by nutritional fanaticism."

"Let's Talk About Food" may be ordered from the American Medical Association at $1.20 a copy mailed to addresses in the United States, Possessions, Canada, and Mexico; $1.50 to all other countries. The remittance should be included with the order.

Orders may be sent to:

American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

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Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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Discusses Next Steps in Implementation Of Heart, Stroke, Cancer Programming

(Editor's Note: The following are excerpts from an address by Robert Q. Marston, M.D., Associate Director, National Institutes of Health, and Director, Division of Regional Medical Programs, to the recent annual meeting of the American Hospital Association.)

"What is the role of the Regional Medical Programs in the current health scene?

"This requires consideration of at least some aspects of that scene.

"The news media, the actions of Congress, and the frequent statements by our National and local leaders document the fact that health is assuming a position of ever-increasing importance as an objective and as a concern of society. The importance of the maintenance and improvement of health as a social value permeates all discussions of the problems of our health systems. It is accompanied by the growing expectation of the public that modern medicine does have the capability to prevent death and to improve the health status of the people.

"The realization that health demands on our resources are limitless and that in the short run the necessary resources are limited is being perceived by the public with increasing and even compelling force.

"WE SHOULD NOT pass up the opportunity to develop in this Nation ways of providing health care that not only overcome social, economic, and organizational obstacles, but also insure that the continued development and extension of our already recognized capability for the most advanced care is woven into the fabric of our health care system.

> *"As one views the current health scene, it seems inevitable that as an increasing proportion of our national wealth is devoted to health and as the expectation for health services continues to rise, there will be marked pressures for the most effective allocation of health resources.*

"These pressures will exert influence in such critical areas as the distribution of resources between short and long-range goals, the distribution of effort between improvements in quality on the one hand and extensions of access to health care on the other; the allocation of resources for general purposes as opposed to targeted objectives; exploration of mechanisms to ameliorate the acute shortage of almost all health talent; and the need to explore the division of responsibility between those health responsibilities carried out through the governmental sector and the responsibilities of the voluntary institutions and organizations.

"EVEN AFTER THESE decisions concerning allocation of resources are determined, the same pressures will require that similar attention be given to the efficiency of the health systems. Questions will be asked concerning the development of better and more widely distributed management talent in health care institutions and the better division of labor among health personnel and facilities including the development of new types of personnel and facilities to fit emerging needs. Emphasis will be given to the promise of increasing productivity through new technology and the overcoming of historical fragmentation both in function and attitude which has led to independently functioning units without regard to the needs of efficiency.

"We would hope that the Regional Medical Programs will be of assistance both in the area of allocation of resources and in the area of increased efficiency in health services. Public Law 89-239 requires that this program also be a mechanism for assuring that the developments that emerge from biomedical sciences in the coming years will encounter a productive environment for innovation and modifications in health care that translates advances in science and technology into improved health status.

"We have at times summarized the Regional Medical Programs as follows:

> *"The focus is on heart disease, cancer,*

stroke, and related diseases, the mechanism is cooperative arrangements, the emphasis is on local initiative, flexibility, and decision-making and the reasons for the emergency and priority of the program are the relationships of science to service.

"The success of the program would be determined to a considerable extent by the ability of those in the regions, as well as on the national level, to interpret accurately the broad and sweeping pressures of the current health scene; and to capitalize on the unique opportunities under this program, not only by measuring the progress of the program in terms of regional achievement, but to delineate the true needs of the region and then approaches to meet these needs in terms of local resources and potential.

"The next steps at the national level fall into several categories: (1) Additional policy development, particularly as far as operational programs are concerned, (2) the development of specialized competence which has been identified as needed by many or perhaps all regions, and (3) the continued exercise of the peer judgment review mechanism which has worked so well in other grant programs.

"As Regional Medical Programs move into operational grants, an increasing emphasis on the substantive problems of heart disease, cancer, and stroke is inevitable. We have utilized the competencies of the categorial institutes at the National Institutes of Health and of the Institute of General Medical Sciences in the past, but anticipate that the participation of those expert in these diseases will be even more crucial to the success of the program both at the regional and the national level in the immediate future.

> *"As we view the steps ahead, we are keenly aware of the opportunity the people in the field will have to speak concerning the nature of regional medical programs, the appropriate level of support and the relationship to other programs as legislation for extension of the program is considered during the next year.*

"The primary purpose of Public Law 89-239 is set forth most clearly in Section 900-B of the Act: 'to afford the medical profession and medical institutions of the nation . . . the opportunity to make available to their patients the latest advances in the diagnosis and treatment of (heart disease, cancer, stroke and related) diseases.'

"Under conditions unexcelled previously in history we are at a time of conviction that this nation has both the potential and the expectation for new orders of achievement in the health field. We have not yet identified the best ways to proceed toward these achievements. It is against the background of the magnitude of the opportunities, the complexities and problems that the Regional Medical Programs are emerging."

Optimism Expressed as AMA-ERF Researchers Look at Smoking-Health

BY CARL BRAHCE
INFORMATION SPECIALIST, UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Already the AMA Education and Research Foundation has made 79 grants totaling $6,090,886 to established researchers to seek answers to the question, "Why is cigarette smoking a health hazard."

That summary report is made by Maurice H. Seevers, M.D., professor and chairman of the University of Michigan Medical School's Department of Pharmacology and Chairman of the AMA-ERF Committee for Research on Tobacco and Health.

"OUR GOAL HAS BEEN to stimulate such interest among established researchers," Doctor Seevers explains. The physician, internationally known for his work on addiction and narcotics, is chairman of the AMA-ERF committee for research on tobacco and health.

Since the program began three years ago, it has awarded $6,090,886 in 79 grants, including four in foreign countries.

RESEARCHERS hope to find incontrovertible scientific evidence of a cause-and-effect relationship between smoking and disease. The research includes studies of cancer and respiratory and cardiovascular diseases.

"Certain respiratory and circulatory diseases show much the same statistical relationship to smoking as cancer does," Doctor Seevers says. "At the same time, they are more prevalent than cancer."

In the past, research dealt with attempts to correlate certain studies with smoking patterns on a statistical basis. This type of research held little interest for laboratory scientists.

Although the answers may be years away, Doctor Seevers is pleased that the program has helped stimulate interest among established researchers.

Grants are awarded for "efforts to encourage and support studies to determine which significant ailments might be caused or aggravated by smoking . . . those mechanisms by which cigarette smoking might affect health . . . and the particular substance or substances in smoke which might be the causal or aggravating agent."

THE PROJECT FOR research on tobacco and health was initiated by the AMA House of Delegates as an adjunct to its educational campaign to discourage the use of toxic materials — including tobacco — among young people.

Following the U.S. Surgeon General's report citing the statistical relationship between smoking and lung cancer and other diseases, AMA delegates indicated that scientific data was needed; statistical tabulations alone were not enough to dissuade smokers from their habit.

To launch a successful educational campaign, scientists would have to define the role of smoking as a causative factor in death and disease, the mechanisms by which tobacco smoke attacks the body.

The tobacco industry has pledged $10 million over five years in support of the research project. If smoking is implicated in disease, the industry wants to know if some specific agent or agents in the tobacco could be removed to make it harmless.

"WHILE THE MEDICAL profession and tobacco industry have somewhat divergent reasons for promoting tobacco research, both are committed to basic scientific research as the best means of developing specific answers to the questions raised by our smoking population," Dr. Seevers explains.

"Certainly, there are no scientific data that would contradict the basic tenets of the surgeon general's report. I believe very few, if any, of the scientists working under this program would advise anyone to smoke. Still, we hope that in the search for facts we can retain an open mind."

MICHIGAN MEDICINE
DEADLINE FOR THIS BREAKING NEWS WAS OCTOBER 20, 1967

Question "Partnership" Proposal

Combined Public Health, Social Services Unit Opposed by MSMS

The MSMS House of Delegates at its annual meeting in September passed two separate resolutions in support of a strong, separate Michigan Department of Public Health as opposed to a combined Public Health - Social Services body.

In so doing the Delegates also directed that the Medical Society make "the most forceful presentation possible" to the Governor of the State of Michigan, recommending the retention of health-related activities within an independent Department of Public Health.

The Delegates urged that services for crippled and afflicted children and also the Medicare-Medicaid programs, among others, be assigned to the Health Department rather than the Social Services Department because "we in Michigan have had experience with organization of health services under both welfare and health divisions," and "the concentration of health-related services under health auspices has been the most effective and productive arrangement."

LETTER TO GOV. ROMNEY:

On October 5, the Chairman of The Council, Robert J. Mason, M.D., Birmingham, directed a communication to Governor Romney that the persistent rumor that certain legislators, governmental employees, and elected state officials were considering merging the two departments (Public Health and Social Services) was a matter of the gravest concern to the entire House of Delegates and The Council.

The letter to the Governor pointed out that it was the doctors of medicine in Michigan who initially urged the creation of a separate and strong Department of Public Health and "who assisted at its birth and nurtured it over the years."

"No other agency," the letter continues, "regardless of whether it too provides certain services to the people, is suited to assume responsibility for public health management."

The letter went on to state that MSMS realizes that this vital agency (Public Health) cannot be submerged within any other governmental department except by action of the State Legislature. "We earnestly hope for your personal assurance that you, as Chief Executive, would consider any attempt to do so inappropriate, regressive, and subject to your disapproval," the letter read.

MSMS pointed out that the Department of Public Health is interwoven with scientific sub-groups of MSMS and with a network of local public and private health agencies.

Extract of MSMS Council Minutes

At its September meeting in Grand Rapids, September 24 and 29, The Council:

Welcomed Kenneth H. Johnson, M.D., Lansing, the newly-elected MSMS Secretary.

Appointed official representatives to the AMA Second National Congress on Socio-Economics of Health Care, to be held in Chicago in March, 1968; and to the Mid-Year Meeting of the Michigan Hospital Association House of Delegates, in Traverse City October 13, 1967.

Appointed a committee to consider the problem of privileges of oral surgeons in hospitals.

Authorized appointment of an MSMS representative to monitor meetings of the Advisory Committee to the Michigan Health Facilities Data Clearinghouse.

Adopted the report of the Subcommittee on General Practice Education re the "Millis Report" and directed that it be forwarded to the AMA Board of Trustees, Council on Medical Service and Council on Medical Education.

Approved nine recommendations of the Public Relations Committee for projects for 1967-68.

Adopted the 1966 AMA statement on "Narcotics and Medical Practice" as guidelines for MSMS, upon recommendation of the Committee on Alcoholism & Drug Addiction.

Approved the distribution of MSMS Medi-labels by responsible lay organizations with the proviso that every organization be instructed that information on the labels should be authenticated by a physician.

Welcomed to The Council James B. Blodgett, M.D., Detroit, and Vernon V. Bass, M.D., Saginaw, newly-elected Speaker and Vice-Speaker, respectively, of the House of Delegates.

Granted a request that Councilors accept responsibility for helping in the scheduling of postgraduate programs in their areas.

Re-elected Chairman Robert J. Mason, M.D., Birmingham; Vice-Chairman Ross V. Taylor, M.D., Jackson; Finance Committee Chairman Robert K. Whiteley, M.D., Detroit; and Publication Committee Chairman Brooker L. Masters, M.D.; and elected as County Societies Committee Chairman John J. Coury, M.D., Port Huron.

Requested Treasurer Ylvisaker to obtain more detailed proposals from various banks re his plan for management of MSMS assets which was "approved in principle" by the 1967 House of Delegates, for the information of The Council.

TB SOCIETY NAMES FIVE PHYSICIANS

Reelected to lead the Michigan Tuberculosis and Respiratory Disease Association for the coming year was Judge Alton H. Noe, Mt. Clemens. Judge Noe was re-elected president at the Association's recent annual meeting in Grand Rapids.

Winthrop Davey, M.D., Ann Arbor, was re-elected first vice president, and physician members of the executive committee who were reelected include Paul Chapman, M.D., Detroit, and Walter Meier, M.D., Monroe.

William H. Knisley, Ph.D., East Lansing, Joseph Bachman, M.D., Tecumseh, and Robert Locey, M.D., Benton Harbor, were newly chosen to three-year terms on the Board of Trustees.

MDs Address Smoking - Health PTA Workshops

Michigan physicians, concerned about smoking - and - health, will speak this month at 14 regional PTA workshops. The workshops are sponsored by the Michigan Congress of Parents and Teachers in cooperation with the Michigan Council on Smoking and Health.

The Workshops will train local PTA leaders in the most effective methods of discouraging young people from smoking.

Further MSMS smoking - and - health activities are being explored by the MSMS Cancer Committee, MSMS Respiratory Diseases Committee and the MSMS Committee on Public Relations.

NEWS IN BRIEF

Clyde T. Hardwick, Ph.D., economic consultant to the Michigan State Medical Society, has been named associate dean of the University of Detroit College of Business and Administration. He has been with the university 22 years and recently was head of the University Center for Continuing Education.

* * *

Kingswood Hospital in Ferndale has re-organized from a proprietary corporation to a Michigan nonprofit corporation. Established primarily as a service for in-patient psychiatric care, Kingswood revised its corporate structure as a preliminary step to achieving recognition by Michigan Blue Cross as a participating hospital. Over 100 psychiatrists are on the open medical staff of Kingswood.

MSMS Begins New Push To Recruit Health Personnel

A new Michigan campaign began in October to recruit more young people for the 200 rewarding careers in medicine and health.

"The Michigan doctors of medicine have pledged their efforts to work to expand the health team," reports B. M. Harris, M.D., President of the Michigan State Medical Society.

ONE HUNDRED BILLBOARDS are going up in Michigan to focus on the appeal that "200 Medical Careers — One May Be Just Right for You." The special recruitment push began during Community Health Week observance, October 15-21. The week was sponsored by the Michigan State Medical Society, Michigan Health Council and the Michigan Association of the Professions.

Many doctors of medicine were active during the special week giving speeches before school assemblies, school clubs, church groups, and other youth organizations.

THOUSANDS OF CAREER folders were distributed in Michigan.

School guidance counselors, science teachers, scoutmasters, college advisors, employment office consultants, and many others have joined the special Michigan effort to interest young people and their parents in the 200 health careers.

Furstenberg, Others Honored by U-M

Emeritus Dean Albert C. Furstenberg, M.D., Ann Arbor, head of the University of Michigan Medical School from 1935 to 1959, is one of eight persons receiving a special U-M Sesquicentennial Award at an October ceremony. Doctor Furstenberg, now 76, still continues his practice at St. Joseph Mercy Hospital.

Among the other awardees were Charles B. Huggins, M.D., Nobel laureate; Charles M. Hudson, M.D., immediate past president of the American Medical Association; Robert R. Shaw, M.D., thoracic surgeon known for his contributions to medical education in Afghanistan; Chester B. McVay, M.D., Ph.D., authority on the technique of hernioplasty which he developed; William A. Sodeman, M.D., leading medical educator; and E. Clifford Upjohn, M.D., chairman of the board of the Upjohn Company in Kalamazoo.

Fralick, Greene Get Top Honors

Among the ten University of Michigan faculty members recently cited for distinguished achievement and service to the University were two physicians.

F. Bruce Fralick, M.D., professor and chairman of the Department of Ophthalmology, was presented a Distinguished Faculty Achievement Award of $1000. Harlan Hatcher, U-M President, presented the award which called Doctor Fralick "a world-renowned ophthalmic surgeon who has brought great distinction to the University."

Doctor Fralick will have retired as Chairman of the Department by July 1, 1968.

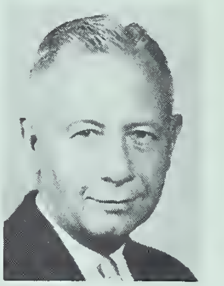
Recipient of a Distinguished Service Award of $500 was James A. Greene, Jr., M.D., associate professor of internal medicine. The Award cited Doctor Greene as "instrumental in introducing programmed instructional material into the clinical laboratory course."

CITED FOR IDEAS

Edward F. Sladek, M.D., Munson Medical Center, Traverse City, and Arthur B. French, M.D., University Hospital, Ann Arbor, were presented special awards for "Achievements directly related to patient care," at a recent Michigan Hospital Association meeting.

The contest was part of the ninth annual Search for New Hospital Achievements cosponsored by the Michigan Hospital Association and Michigan Blue Cross.

Five Colleges To Hear Talks On Nutrition



Edgar Gordon, M.D., of Madison, Wisconsin, a national authority on human nutrition, is speaking at five Michigan colleges this school semester. Doctor Gordon, keenly interested in isotopes, endocrinology, metabolism and related subjects, is now professor of medicine and chief on the metabolism and endocrinology clinic at the University of Wisconsin medical school. He comes to Michigan under the sponsorship of the AMA Council on Foods and Nutrition, the MSMS Education Liaison Committee, and the county medical societies in the home communities of the colleges.

Dates for the college lectures:

October 5 — Hope College

October 30 — Central Michigan University

October 31 — Ferris State College

Date undetermined — Northern Michigan University

Date undetermined — Western Michigan University

Michigan Medicine Article Cited as Best in Economics

October 16 was a proud day for the MSMS Committee on Medical Socio-Economics and the MSMS Publication Committee.

Indirectly the work of the two committees was cited for a national award on that day in Washington, D.C.

The story goes like this . . .

The National Association of Blue Shield Plans presented a coveted award October 16 to Charles P. Hall, Jr., Ph.D., for the "most scholarly contribution to the literature of medical economics" for the past year — for his article in the January 1967 issue of *Michigan Medicine.* The article, entitled "The Future of Health Insurance, Prepayment and Medicine," was the first in a series of papers by national authorities commissioned by the MSMS Committee on Medical Socio-Economics. The second article in the series also has appeared in the MSMS journal and others will appear during the coming year.

Mr. Hall is a professor of insurance at Temple University.

The award given to Professor Hall is the annual Norman A. Welch, M.D. Award, created for Doctor Welch by NABSP.

Ferment in Medicine, by Richard M. Magraw, was the 1966 winner.

NABSP has requested permission from the Publications Committee to reprint the paper in pamphlet form for distribution to those persons interested in prepayment medical insurance and the socio-economic aspects of medicine.

CAREERS MOBILE PLANS DETROIT INNER-CITY STOPS

The Health Careers Mobile will be stationed at various inner-city junior high schools soon in the Detroit area in an effort to encourage young people to enter health careers. The Mobile, sponsored by the Michigan Health Council and the Michigan State Medical Society, will have the cooperation of the Detroit Public Schools system. Plans are now underway for a visit of the Mobile in the spring to those junior high schools not visited previously.

The Mobile will make a stop December 4-6 at the Michigan Education Association Conference Center in Battle Creek where the Health Council, Michigan Personnel Guidance Association, and Western Michigan University will hold a meeting on health careers.

Recently the Mobile has been at Frankenmuth, Saginaw, and Flint high schools, Battle Creek for Community Health Week, Central Michigan University in Mount Pleasant, and at the Western District Hospital Auxiliary meeting in Ludington.

Explain MARMP To Chairmen

A special meeting was held at the MSMS Headquarters October 18 to report the progress of MARMP to chairmen of MSMS related committees.

Don Marshall, M.D., Kalamazoo Councilor and Vice-Chairman of the Michigan Association of Regional Medical Plans, called the meeting and invited the chairmen of the MSMS committees which have an interest in the MARMP scope of activities.

The speakers included Albert E. Heustis, M.D., now the executive director of MARMP.

SINAI OFFERS SERIES

Physicians are invited to attend the 1967-1968 Wednesday Evening Rotating Lecture Series of the Department of Psychiatry at Sinai Hospital in Detroit November 8 through December 27, at 7:30 p.m.

Presenting the lectures will be Elliot D. Luby, M.S., professor of psychiatry and law at Wayne State University School of Medicine, and assistant director of the Lafayette Clinic.

DOCTORS HEAR LEGISLATORS

Physicians and politicians got together to discuss legislation to improve medicine at a recent meeting of the Muskegon County Medical Society.

Pictured speaking at left is Senator Oscar "Bud" Bouwsma, and seated at his left is Representative Francis W. Beedon. Discussing issues of mutual interest, at right, are F. James Stubbart, M.D., left, M. A. Riley, MSMS staff, center, and Senator Bouwsma.

"Repeat after me," says Robert J. Mason, M.D., Birmingham, Chairman of The Council, as he administers the oath of office to Incoming President Bradley M. Harris, M.D., Ypsilanti, right. Mrs. Harris observes the proceedings at the State Society Dinner Dance.

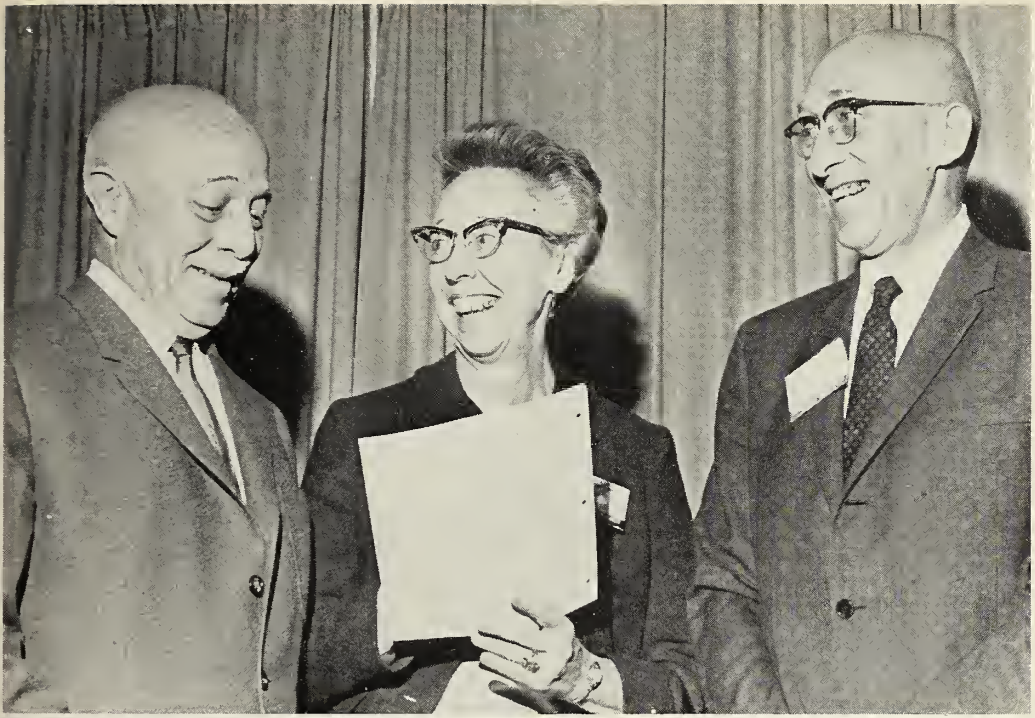
More Photos From MSMS 1967 Annual Session

Some photos from the Annual Session already have appeared in the October News Extra and others will appear in future issues of Michigan Medicine.

AT LEFT — The new MSMS President, Bradley M. Harris, M.D., Ypsilanti, presents Outgoing President C. Allen Payne, M.D., Grand Rapids, with the Past President's Plaque following the installation ceremony at the Dinner Dance.

ABOVE TWO PHOTOS — Taking notes at the MSMS House of Delegates for future reference are medical school students invited by MSMS to observe proceedings at the Annual Session. Pictured are representatives from the Wayne State University and the University of Michigan medical schools senior classes.

AT RIGHT — Dwight L. Wilbur, M.D., left, AMA President-Elect, was introduced to the House of Delegates by Luther R. Leader, M.D., MSMS Past President and Chairman of the MSMS Delegation to the AMA House of Delegates.



Listening to the remarks of Congressman Gerald Ford, Minority Leader of the House of Representatives, are Vernon V. Bass, M.D., Saginaw, Chairman of MDPAC, and many other members at the MDPAC Breakfast during the MSMS Annual Session.

Above, Left — Having a family reunion at the MSMS Annual Session are the three Doctors Harris. Isabel Harris, Ph.D., center, and Scott Harris, M.D., Plymouth, right, smile their congratulations at their brother, Bradley M. Harris, M.D., Ypsilanti, the new MSMS President. Doctors Scott and Bradley Harris are twins. Doctor Isabel Harris is a professor of nursing education at the University of Minnesota.

Esther D. Schulz, R.N., Ph.D., Sex Information Council of the United States, spoke at the Public Forum on "Family Life and Sex Education — Neglect or Overemphasis." Listening at the head table are, left to right: W. W. Jack, M.D., Grand Rapids, chairman of the MSMS Maternal Health Committee; Eleanor P. Skufis, M.D., Adrian, secretary for the program; and Robert E. Rowe, M.D., Port Huron, presiding chairman.

MSMS 50-YEAR PINS GIVEN 41 DOCTORS BEFORE DELEGATES

Forty-one Michigan doctors of medicine, who have practiced 50 years, were honored by the Michigan State Medical Society in Grand Rapids.

The House approved the coveted half-century service pin for the following:

Dickinson-Iron: William J. Kofmehl, M.D., Stambaugh

Genesee: J. Leonidas Leach, M.D., Flint; R. G. Brain, M.D., Flint

Gratiot-Isabella-Clare: Myron G. Becker, M.D., Edmore

Ingham: William C. Behen, M.D., Lansing; Charles A. Behney, M.D., now in Bisbee, Arizona; Maurice C. Loree, M.D., Lansing; Arthur W. Newitt, M.D., Lansing; T. P. VanderZalm, M.D., Lansing

Jackson: Miar J. McLaughlin, M.D., Jackson

Kent: William J. Butler, M.D., now in Tucson, Arizona; Harry Lieffers, M.D., Grand Rapids

Macomb: William Kane, M.D., Mt. Clemens; Arthur Erkfitz, M.D., St. Clair Shores

Oakland: Ira M. Altshuler, M.D., Southfield

Ottawa: William C. Kools, M.D., Holland

St. Clair: G. Douglas Treadgold, M.D., Port Huron

Shiawassee: Alfred L. Arnold, Jr., M.D., Ovid

Washtenaw: Algernon A. Palmer, M.D., Chelsea

Wayne: Domenico M. Annessa, M.D., Detroit; Lloyd K. Babcock, M.D., Detroit; Isadore I. Bittker, M.D., Oak Park; William L. Brosius, M.D., Rochester; Robin Buerki, M.D., Detroit; John M. Carter, M.D., now in Ft. Lauderdale, Florida; Leon B. Cowen, M.D., Detroit; Robert L. Cowen, M.D., Detroit; Howard P. Doub, M.D., Detroit; James W. Hawkins, M.D., now in Sarasota, Florida; William E. Henderson, M.D., Harper Woods; Herbert I. Kallet, M.D., Detroit; Edward D. King, M.D., Grosse Pointe; Joseph S. Leszynski, M.D., Detroit; John W. MacKenzie, M.D., Grosse Pointe; William T. McAlonan, M.D., Detroit; Vasil P. Moisides, M.D., Detroit; C. W. Sellers, M.D., Detroit; Elmer C. Texter, M.D., Detroit; Roy D. Tupper, M.D., Detroit; Clarence E. Weaver, M.D., now in Deerfield Beach, Florida

Igna, Bogue Lead State Ob-Gny Society

The Michigan Society of Obstetricians and Gynecologists are being led this year, 1967-68 by Eli J. Igna, M.D., Grosse Pointe, president, and Robert Bogue, M.D., Detroit, president-elect.

Other officers for 1967-68 are Joseph B. Woolfenden, M.D., Detroit, secretary, and John M. Malone, M.D., Detroit, treasurer.

mediscene

Nov. 8 — The Council, MSMS Headquarters, East Lansing

Nov. 15-17 —International Conference on Fertility and Family Planning — A World View, University of Michigan Medical School, Ann Arbor

Nov. 26-29 — AMA Clinical Convention, Houston

Nov. 26-29 — Conference on Genetics in Medicine, sponsored by the American College of Physicians, University of Michigan Medical School, Ann Arbor

Dec. 4-5 — Institute for Guidance Councilors, Michigan Education Association Conference Center, St. Mary's Lake, Battle Creek

Dec. 6-7 — Conference for Head Nurses, Kellogg Center, East Lansing

Dec. 6-7 — 15th Annual Symposium on Trauma, WCMS Headquarters, Detroit

Dec. 13 — The Council, MSMS Headquarters, East Lansing

March 26-27 — Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 23-28 — Student American Medical Association meeting, Detroit

May 1-8 — Mental Health Week

HEALTH COUNCIL OFFERS TWO BABY CARE POSTERS

One of the most popular publications of the Michigan Health Council is the Baby Emergencies Poster, produced in 1960 in cooperation with the University of Michigan's Department of Pediatrics. The initial 400,000 posters printed with a grant from the Gerber Baby Foods Fund have been distributed free to parents, baby sitters and other interested persons.

In 1961, a similar publication, Baby Health and Safety Tips, was produced through a grant from Parke, Davis and Company. Four hundred thousand copies are being distributed offering valuable tips on how to take precautions for youngsters' health and safety. Parke, Davis also has provided a grant to the Michigan Health Council that has made it possible to reprint the Baby Emergencies Poster.

Copies of the two posters may be obtained from MSMS, 120 West Saginaw, East Lansing 48823.

These are the features* you specifically wanted in an infant formula

SHAKE WELL BEFORE OPENING
MODILAC
BEFORE OPENING SHAKE WELL
CONTENTS 13 FLUID OUNCES
Gerber
BABY FORMULA
MODILAC
READY PREPARED · JUST ADD WATER

You'll find them all in Modilac,™ the Gerber Baby Formula. A complete milk formula, its nutritional structure is as follows:

IRON

10 mg. per quart of normal (1:1) dilution to help prevent iron deficiency anemia. When fed in typical amounts, the NRC Recommended Daily Dietary Allowance[1] for iron will be met.

FAT

Corn oil completely replaces butterfat providing ample linoleic acid. A clinical report[2] indicated that this important fatty acid plays a definite metabolic role in infants, providing efficient caloric utilization.

VITAMINS

A, C, D, B_6 and E are added in sufficient quantities to meet the infant's needs. No further supplementation required.

PROTEIN

Protein level of the Gerber Baby Formula is intermediate between that of breast milk and cow's milk. Protein efficiency has been clinically established.[3]

CARBOHYDRATES

Modilac offers a blend of carbohydrates for spaced assimilation—38% lactose and 62% dextrins-maltose-dextrose.

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*A survey among pediatricians and GP's indicated that the features listed above were considered the most important in infant formulas.

[1] Publication 1146, National Academy of Sciences—National Research Council, 1964.

[2] Adam et al: Essential Fatty Acids in Infant Nutrition. II. Effects of Linoleic Acid on Caloric Intake, J. Nutrition 66: 555-564, 1958.

[3] Lowe, Charles U., M. D., Mosovich, Luis L., M. D., and Pessin, Vivian, Ph.D.: Effects of Protein Level and Type of Heat Treatment of Milk Formulas on Growth and Maturation of Infants, J. Pediatrics 64: 666-682 (May) 1964.

Gerber

"Tomorrow
in Today's Hands"
...through
Gerber Research.

Gerber Products Company, Fremont, Michigan 49412

What image does the public hold of doctors? Is that image good and how can it be improved? If that image is poor, then how can it be improved?

These questions recently were raised in an AMA survey among county and state medical society executives. The results were revealed at the AMA Communications Institute where Brock E. Brush, MD, Detroit, Chairman of the MSMS Committee on Public Relations, led a sizeable Michigan delegation. (Other problem areas — such as physician-patient relationships, costs of medical care and the shortage of doctors — were covered in some detail in the September issue of *Michigan Medicine.*)

The following were listed as major problems under image and community concern:

"The nationwide effort to discredit the profession . . . necessary changes in the practice of medicine have not been explained to the public . . . physicians lack time and means to convince the public that MD's are not entirely concerned with money . . . doctors are so preoccupied with their tarnished image, and talk about it so much, that they have convinced their friends and business acquaintances that it's true . . . the public does not understand why doctors oppose government programs or even government control . . . medicine has a negative image after years of battle over government health programs . . . when doctors oppose a program, the public thinks it's because they can make more money another way . . . there is a lack of identity with community problems and the public can't see the profession doing anything about the problems people are talking about . . . lack of rapport with the public . . . not enough concern about the community . . . and medicine is too concerned with little problems and not concerned enough about really big ones in this country.

"It is significant that few of those problems exist in the small medical society, where the doctors are well known in the community and are involved in community affairs . . . where they have time to chat a few minutes with their patients . . . and where they treat most of the various ailments of the entire family. The basis for the problems seems to be bigness . . . and everything in this country — except the dollar — is getting bigger all the time.

"Here are the main solutions suggested: get across our views on current problems . . . let the public know our goals . . . see that welfare patients get care whenever they need it . . . explain the charges and services under Medicare . . . educate MD's and their wives in community relations . . . physicians should be leaders and not followers in the community . . . doctors need more contact with business people and with the public . . . help meet the health needs of the community . . . better liaison with welfare agencies . . . more school courses on VD and smoking . . . make the public aware of problems facing the physician . . . explain MD activities in promoting public welfare . . . find solutions to health problems at the local level . . . be totally involved in all facets of health care . . . And finally, make an intensive analysis of health care needs; develop sound programs to meet them; and conduct a campaign to see that the programs work."

Warns Against Medicare Payment Logjam Costing Doctors More in Tax Dollars

(This article is reprinted with permission from DOCTOR'S TAX REPORT, the bi-weekly newsletter by Prentice-Hall, Inc., of Englewood Cliffs, New Jersey, offering physicians personal and professional tax information and advice.)

One of the most frequent complaints we hear from doctors throughout the country after the first year of Medicare is, "Why is there such a long delay in receiving payment?"

We hear there's sometimes a three- or even a four-month time lag between billing and payment in some localities. And what's even more important than mere delay from your tax point of view is that you may receive a large batch of payments *all at once*. If you find yourself facing this year-end, income-bunching problem, here's—

WHAT TO DO

Start planning immediately to see how you can use one or more of these tried-and-true tax-saving techniques to cushion the impact of receiving substantial Medicare payments all at once: (1) Income averaging; (2) Accelerating '68 payments; and (3) Shifting other income and deductions. Let's look at them in detail.

(1) **Income averaging:** In effect, income averaging spreads bunched income over the current and preceding four years. Its basic requirement is that your income for the current year exceeds 133⅓% of your average income for the preceding four years by more than $3,000. If you qualify—and, remember, you must *elect* income averaging, it's not given to you automatically—you can go a long way toward taking the tax sting out of a batch of bunched Medicare payments.

(2) **Accelerating '68 payments:** One thing is certain—tax bills will go up next year. And right now, it looks as though the effective date for the surcharge tax on individuals will be January 1—at least 6%. One practical way to avoid this added tax on bunched Medicare payments coming in '68 is to see that your paper work is done right now. If you practice in an area where your Medicare carrier is prompt in making payment, instruct your aides to bring every Medicare patient's file up to date. By processing every claim to the carrier without delay, you'll accelerate potential '68 income into '67 and avoid the surcharge.

(3) **Shifting income and deductions:** Suppose, however, you have the reverse problem and can anticipate a bunched Medicare payment from your carrier in '67. In that case, you'll want to watch your billing practice carefully during the last three months of the year and defer some of your regular billings into '68. Not until you receive the payments next year will you have to take them into income. Despite the surcharge tax in '68, you may be better off in the long run by so deferring a portion of your '67 earnings. What's more, many items—such as medical and office supplies—are deductible when paid, so timing the payment fixes the year of deduction. You can substantially increase your '67 practice-connected deductions to offset income-bunching by ordering and paying for many necessary items before the end of the year.

SUMMING IT UP

A quick review of your financial and tax picture may point up how income averaging, discounting payments, and shifting income and deductions—or a combination of all three—can save you many tax dollars next April 15. We'll describe these and other tax saving techniques in greater detail in subsequent issues.

RATES MANPOWER SHORTAGE AS GREATEST PROBLEM

The world's greatest health problem is not cholera or smallpox or even overpopulation. It is the lack of doctors and nurses and others to battle disease.

Marcolino Candau, director general of the World Health Organization, threw that implicit challenge to the world's nations at a recent University of Michigan Voices of Civilization program.

He reported that Asia and South America are meeting this problem somewhat with new medical schools, though both are struggling to keep up with skyrocketing populations. In Africa, virtually nothing is being done. Latin America, with 200 million people, has 128 medical schools taught by Latin Americans.

Houston, host on November 26-27 for the AMA Clinical Convention, enjoys a semi-tropical climate and sunbathing and swimming almost year round. The city's many public and private pools greatly enhance the leisure hours spent by conventioneers and recreational travelers. Pictured is a typical example of one of Houston's private pools at one of the city's fine motor hotels.

AMA CLINICAL EVENT NOV. 26-29, HOUSTON

A scientific program especially designed for the physician in practice again will be featured at the AMA's Clinical Convention, to be held here November 26-29.

The four-day meeting will include scientific sessions on 18 major topics, four postgraduate courses, breakfast roundtable conferences, closed-circuit television and medical motion picture programs, and more than 150 scientific exhibits.

Of special interest are the postgraduate courses, expanded to four topics: Fluid and Electrolyte Balance, Oncology, Cardiovascular Disease, and Obstetrics and Gynecology. Each course will consist of three half-day sessions featuring outstanding teachers.

Topics at the general scientific sessions include: aerospace medicine, antibiotics, arthritis, cancer, cardiovascular medicine, cardiovascular surgery, dermatology, endocrinology, gastroenterology, general surgery, genitourinary treatment, geriatrics, obstetrics and gynecology, ophthalmology, otolaryngology, pediatrics, and psychiatry. There also will be a session on "new cares" featuring a discussion of legal and social problems now faced by the physician.

Breakfast Roundtable Conferences will discuss (1) Indications and Limitation of Uses of Antibiotics, (2) "The Moral and Ethical Aspects of Caring for the Dying Patient," (3) "Management of Cerebrovascular Insufficiency," and (4) Adolescence, Age of Rebellion; Some Related Psychiatric Aspects."

Scientific and industrial exhibits and all scientific meetings will be in Houston's new Astro Hall, a part of the Astrodome complex.

The AMA's policy-making House of Delegates will meet at the Shamrock-Hilton Hotel.

48 from Michigan Inducted as Fellows Of College of Surgeons

Forty-eight Michigan physicians were among the 1,445 surgeons — the largest number in the history of the College — were inducted as new Fellows of the American College of Surgeons in cap-and-gown ceremonies during the recent annual Clinical Congress.

Following are the names of the Michigan doctors so honored:

Adrian: Landis C. Stewart.

Ann Arbor: Roger Boles, Bruce E. Cohan, John W. Henderson, S. Martin Lindenauer, Nels R. Olson, Sathaporn Vathayanon.

Battle Creek: Frank L. Lanuti.

Birmingham: James E. Ladd.

Detroit: Donald C. Austin, Conrad F. Bernys, Philip J. Feringa, Thomas A. Fox, Jr., Vincent J. Gallant, Warren G. Hardy, Kamil Imamoglu, Angelos A. Kambouris, Donald I. Kapetansky, Carl E. Kuntzman, Kim K. Lie, James J. Whitten, Burton J. Zack.

Farmington: Howard N. Manz.

Ferndale: Frank A. Young.

Flint: Robert L. Cross, Roy D. Diggs, Jr., Vernon C. Urich.

Grand Rapids: Patrick F. Jewell, Haven E. Jones.

Hastings: Gordon M. Finnie.

Lansing: Joseph L. Sheets.

Livonia: Albert J. Tactac.

Marquette: Edward F. Kronschnabel, Fred C. Sabin.

Midland: William A. Harrigan, Charles A. Sanislow.

Mount Clemens: Sorab A. Colah.

Muskegon: Guido W. Annessa.

Niles: Donald C. Camp.

Petoskey: Robert E. Shanahan.

Pontiac: Oliver W. Page, Jr.

River Rouge: John L. Loomis.

Roseville: Robert H. Ambrose.

Royal Oak: W. E. Barry Mayo, Stanko Stanisavljevic.

St. Joseph: Warren A. Wise.

Traverse City: Donald G. Pike.

Wyandotte: B. Carl Mahanti.

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prolonged action, with high blood levels, then you know
hy b.i.d. DECLOMYCIN is considered to be a
ensible dosage schedule.

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an be kept at this convenient schedule
ecause of its unusually high effective blood
nd tissue levels.

he b.i.d. dosage of DECLOMYCIN gives you
he comfortable assurance that the patient
well-covered, *day and night.*

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therapeutic dose of DECLOMYCIN are
igh, prolonged, and effective; because of
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And if there's a broader susceptibility
attern of organisms, we've yet to see it.

here is no need to give higher daily dosage
han 300 mg b.i.d., except in venereal diseases
nd Eaton Agent pneumonia.

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Prescribing information on next page.

ADVANCES
GAN DOCTOR

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risked his life to save a patient."

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CHILDREN ELECTS
W PRESIDENT

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b.i.d. The sensible schedule that covers the patient day and night

DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

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Bill Boynansky

"The patient who thinks he's an airplane is here to see you, doctor."

HEALTH NEEDS RATED LOW IN DETROIT POLL

A Detroit poll conducted by United Community Services of community needs rated "health and medical services to all citizens" as tenth in the list.

About 750 Detroit area residents participated in the poll in an attempt to determine the greatest needs in Detroit.

Problems which worry Detroiters are, in order of importance:

1. Crime and delinquency.
2. Breakdown of the family.
3. Education in low income areas.
4. Housing for the poor.
5. Employment for the unskilled and handicapped.
6. Opportunities for minorities.
7. Air and water pollution.
8. Adequate subsistence for the poor, uneducated, handicapped and unemployable.
9. Alcoholism and drug addiction.
10. Health and medical services for all citizens.
11. Need for citizen participation in community planning.
12. Recreation and open space.

RECALLS ADVANCES BY MICHIGAN DOCTOR

(Editor's Note: *Kalamazoo Medicine,* the official publication of the Kalamazoo Academy of Medicine, carries "The Best of Bodmer" each month as one of its features. Harvey C. Bodmer, M.D., each month offers comments and often writes about the history of medicine in Michigan. The following short sketch about William Addison Stone, M.D., appeared in the September issue)

"William Addison Stone, M.D. first practiced at Almont, Michigan, with his uncle, Dr. Addison Ray Stone, who had been a surgeon attached to General Custer's Cavalry regiment during the Civil War. While Dr. William Stone was at the Traverse City Hospital for the Insane he collaborated with Dr. G. E. Chaddock to make the first English translation of Krafft-Ebing's Psychopathic Sexuals. This became the first English exposition on general paresis of the insane, and marked an advance in the method of diagnosis of causes of insanity.

"While at the Kalamazoo State Hospital Dr. Addison Stone introduced many innovations for the training of interns and nurses. He also initiated the idea of practical agricultural as therapy, organizing Brook Farm and Colony Farm (toward Oshtemo). He also started the first nurses' training school in the Mid-West for the care of the insane sick.

"He organized a fire department and fire drills. During the first few months the need became obvious. A serious fire occurred in one of the buildings where he risked his life to save a patient."

STATE ASSOCIATION FOR RETARDED CHILDREN ELECTS MANIACI NEW PRESIDENT

The Michigan Association for Retarded Children at its 6th annual meeting in Lansing recently elected George D. Maniaci, M.D., Gladstone, as president.

"While mental retardation has now entered the inner circle of respectable handicaps," Doctor Maniaci said in addressing the more than 300 people attending the meeting, "it is not respectable to allow a child's abilities to stagnate for lack of educational or training programs which would make him a useful and contributing member of his community."

The Association called upon the state to continue its progressive action on behalf of the retarded.

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AT YOUR SERVICE

If you have questions on Medicare, Medicaid or other Federal/State medical programs that need answering, don't hesitate to contact the MSMS office.

A complete file of books and material is available for handy reference. If the answer to your question is not readily available, attempts will be made to find one and provide whatever data is available.

Blues Support Use Of Private Sector In Federal Programs

The National Association of Blue Shield Plans has declared that complications in the Medicare and Medicaid programs can be lessened through greater use of the private sector.

The Association's views on the two government-financed health care programs were presented by Ira C. Layton, M.D., Vice Chairman of the Board of NABSP, in testimony before the Senate Finance Committee in Washington, D.C., on H.R. 12080, the Social Security Amendments of 1967.

Doctor Layton, a practicing physician in Kansas City, Missouri, pointed out that a "comprehension gap" on Medicare still exists. He added that every effort must be made to simplify the program through administrative changes and greater use of the experience and capabilities of the private carriers involved in the program.

Observing that a recently implemented Medicaid program is being purchased from one of the Plans with Federal-state funds, Doctor Layton said he believed that Blue Shield was beginning to be used to its fullest extent under this program. He urged a continuation of this trend, explaining:

"Only in this way can Blue Shield Plans serve the public under government programs with the same degree of efficiency, economy, and satisfaction that we have achieved in serving our more than 60 million regular subscribers."

Thirty-three Blue Shield Plans are now serving as Part B carriers under Medicare for 60 percent – about 10 million – of the aged beneficiaries. These Plans are processing Medicare claims at a rate of 30 million bills a year.

Under the Federal-state Medicaid program, 12 Blue Shield Plans are involved. They are processing Medicaid claims at a rate of 25 million bills a year.

Appearing today with Dr. Layton before the Committee were John W. Castellucci, President of the Association, and John C. McCabe, President of Michigan Blue Shield, a Part B Medicare carrier, and co-chairman of the Part B Carrier Advisory Group.

PATHOLOGISTS HEAR CORNELL EDUCATOR

The Michigan Society of Pathologists Fall Seminar October 14 at the William Beaumont Hospital in Royal Oak heard Frank W. Foote, M.D., discuss "Tumors of the Head and Neck." He described difficult, complex cases of tumors of the head and neck area.

Doctor Foote, professor of pathology at the Cornell Sloan-Kettering Institute and Memorial Hospital of New York City, emphasized the great necessity for careful examination of the lesions and accurate diagnosis to improve proper care of the patient.

Averill Honored By Planning Reserve

Walter C. Averill, Jr., Saginaw, has been honored with the first Distinguished Service Award ever presented by the Hospital Research and Educational Reserve of Michigan, Inc., an organization he has served as president since it was organized in January of 1963.

Mr. Averill, who recently resigned as president of the Reserve, was cited in the award for his dedicated efforts in behalf of the voluntary hospital system in Michigan and particularly for his service in the development of area, regional and statewide health facilities planning programs.

Anson Hedgecock, Consumers Power Company vice president has been elected to succeed Mr. Averill as president of the Reserve.

ACP OFFERS COURSE AT U-M, NOV. 27-30 ON MEDICAL GENETICS

The American College of Physicians (ACP) will sponsor a four-day postgraduate course on medical genetics, Nov. 27-30, at the Medical Science Building at the University of Michigan Medical Center.

The ACP course will present aspects of medical genetics in a daily series of four or five formal presentations, followed by workshops in which the participants will join different groups according to their interests. Basic concepts, as well as advanced information in genetics will be presented, including recent advances in inherited biochemical variations in man, population genetics and the applications to genetic study of computers.

James V. Neel, M.D., Ph.D., Professor of Human Genetics at the University of Michigan Medical School, is course director. Faculty will be drawn from the University of Michigan Medical School, with guest lecturers from Cornell Medical College, Johns Hopkins University, the University of North Carolina, the University of Washington and the University of Texas Graduate School of Biomedical Sciences.

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Precaution: same as 16 mg. of phenobarbital

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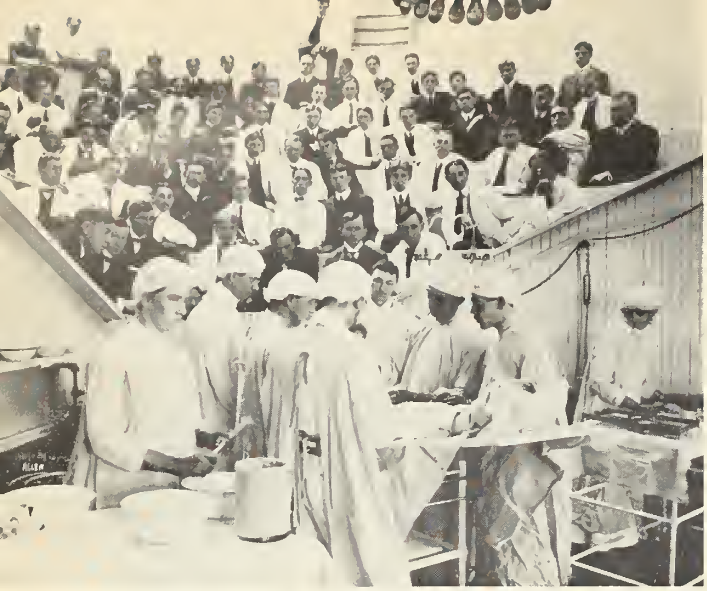

Men and women medical students watch demonstration of surgery in the University of Michigan Medical Amphitheatre about 1900. The first medical building was destroyed by fire in 1911, and many early class pictures were lost.

Michigan Colleges Enroll Over 300,000

The number of students in Michigan public and private colleges and universities this fall pushed well over the 300,000 mark for the first time.

State Superintendent of Public Instruction Ira Polley reports higher education enrollment totaled about 295,000 in the 1966-67 school year and will be about 315,000 this year. This is a gross figure which includes all persons attending college full or part-time.

"Our fast-developing system of community colleges in Michigan is certainly one of the most dramatic aspects of education in the state," Superintendent Polley said. "In 1962, some 31,000 students were attending the 16 two-year public institutions. This fall there may be more than 80,000 students at 24 such institutions—more than twice as many students in 50 percent more community colleges than just five years ago."

The newest two-year institution is Glen Oaks Community College which opened its doors this fall at Centreville, south of Kalamazoo. It is expected that four more community colleges will be in operation within the next two years.

Superintendent Polley also said that state financial assistance to college students this year reaches a high of nearly $10 million through scholarships, grants and guaranteed loans.

More than 13,000 students are attending 88 higher education institutions backed by about $5,250,000 in state competitive scholarships. The scholarship program, which began in the fall of 1964 for freshmen only, this year for the first time will be serving freshmen through senior classes.

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*Paregoric (equivalent) .... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... (2½ grains) 162 mg.
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Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

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Begin Special Cardiac Clinic for Veterans

In conjunction with its Cardiac Catheterization and Open Heart Surgery Programs the Ann Arbor Veterans Administration Hospital is starting a Special Cardiac Clinic for the evaluation of patients who may be candidates for operative therapy. Any eligible veteran may attend this clinic upon referral by his personal physician.

After initial evaluation by members of the Cardiology and Thoracic Surgery (Cardiac) sections, some patients will be scheduled for diagnostic cardiac catheterization. The referring physician will be advised of the initial clinic findings, the results of the cardiac catheterization and the final opinion concerning the indications for or contraindications to operative therapy. In all instances recommendations concerning non-operative treatment will be made to the referring physician by members of the staff of the Section of Cardiology.

The new clinic will meet every Monday from 9-11 A.M. at the Veterans Administration Hospital in Ann Arbor.

BON SECOURS OFFERS BREAKFAST SERIES ON ENDOCRINOLOGY

A weekly series called "Recent Advances in Clinical Endocrinology" will begin January 4, 7:00 a.m. at Bon Secours Hospital in Grosse Pointe.

The series of breakfast meetings will be held each Thursday, ending on March 20.

A detailed program and additional information can be obtained from Nelson Taylor, M.D., Bon Secours Hospital, 468 Cadieux Road, Grosse Pointe, Mich. 48230.

CLINICAL SOCIETY OF STATE DIABETES ASSOCIATION TO MEET

Interested physicians are invited to attend a special symposium of the Clinical Society of the Michigan Diabetes Association at Sinai Hospital, Detroit, November 15.

MDA President John B. Rowe, M.D., Flint, announces that the program about "Some Current Questions about Diabetes" will feature John A. Colwell, Chicago; Buris R. Boshell, M.D., Birmingham, Alabama; Richard A. Field, M.D., and Nicholas Zervas, M.D., both of Philadelphia.

Among the Michigan physicians who will participate on the program are George C. Thosteson, M.D., Fred W. Whitehouse, M.D., Herbert A. Ravin, M.D., and Henry D. Kaine, M.D., all of Detroit, and Keats K. Vining, Jr., Grand Rapids.

Programs and reservation blanks are available from the Michigan Diabetes Society, 10737 W. McNichols, Detroit 48221.

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SIDE EFFECTS of significance have not been reported. However, the risk of vaccine-induced poliomyelitis, estimated to be from 1:2,500,000 to 1:50,000,000 should be considered.

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book reviews

A MANUAL OF CLINICAL ALLERGY. By John M. Sheldon, Robert G. Lovell, and Kenneth P. Mathews. Second Edition. 550 pp. Illustrated. $15.00 W. B. Saunders Company, 1967

The first edition of this manual was published in 1953, so considerable time elapsed between editions making many changes necessary. In addition to this, a number of chapters have been added or rewritten by new members of the allergy teaching staff at the University of Michigan Medical Center.

The use of the word manual as a part of the title of this book is well chosen in some respects but perhaps misleading in others. A good deal of practical instruction is given throughout the text and in the appendices which will be of value to the individual who has not carried out some of the techniques used in the diagnosis and treatment of allergic disorders. However, the main features of the book are a fairly comprehensive text that covers almost all of the problems that would be met with in the practice of allergy. This includes both theoretical considerations such as those covered in the first chapter of immunology and immunochemistry of allergy and a description of the allergens that are responsible for the symptoms of hay fever and other related conditions. The reviewer feels that there might have been some benefit from putting most of the material that normally would go into a manual as a part of the appendices. As the book is arranged, there are some chapters that cover this type of material that are incorporated into the general text.

The book is generally well written and the material very fairly presented. Obviously, a group of allergists who have worked together are going to have certain prejudices as far as their outlooks are concerned. However, I believe that they have made a very fair approach to all controversial questions by either stating all viewpoints or mentioning that not all authorities agree with the author. Due to the multiplicity of authors, there is a certain unevenness between chapters, but generally speaking, it has been very excellently edited. Although the first chapter on immunology and immunochemistry is perhaps adequate, it does not delve deeply into the problem and very frequently avoids discussion of some interesting theories by simply stating that exact knowledge is not presently known. This kind of superficiality perhaps cannot be avoided in a text of 550 pages that covers the entire field of allergy. A number of the photographs are certainly unnecessary and add little. For instance, there are a number of illustrations of nurses giving injections which any purchaser of this book would already know about in detail. Some of these illustrations are not quite close enough to the subject to be particularly helpful even to the neophyte. Another example is the long list of allergens such as the fungi on pages 407-409. I doubt that the average individual who is going to practice allergy would ever refer to this list as a means of identification of yeast or fungi.

Occasionally the authors will make statements such as "some physicians" or "most physicians" in the text. It seems to me that such references confuse rather than aid the reader. If the authors are covinced that a particular procedure is valuable and has proven to be so, this should be stated. If there are disagreements in the literature or from other experts, these might be quoted. Not infrequently, also, trade names are used and their nonproprietary name is not indicated.

These criticisms are really very minor when considering this excellent text as a whole. It can be strongly recommended both to the student and the practitioner. Where it is not encyclopedic in nature, the text contains most of the information which would be useful. There are very few omissions. (One that could not be found in either the text or index was the fairly frequent occurrence of goiter secondary to chronic iodine medication.) Directions are clearly given and the illustrations are excellently reproduced.

George H. Lowrey, M.D.
Scientific Editor

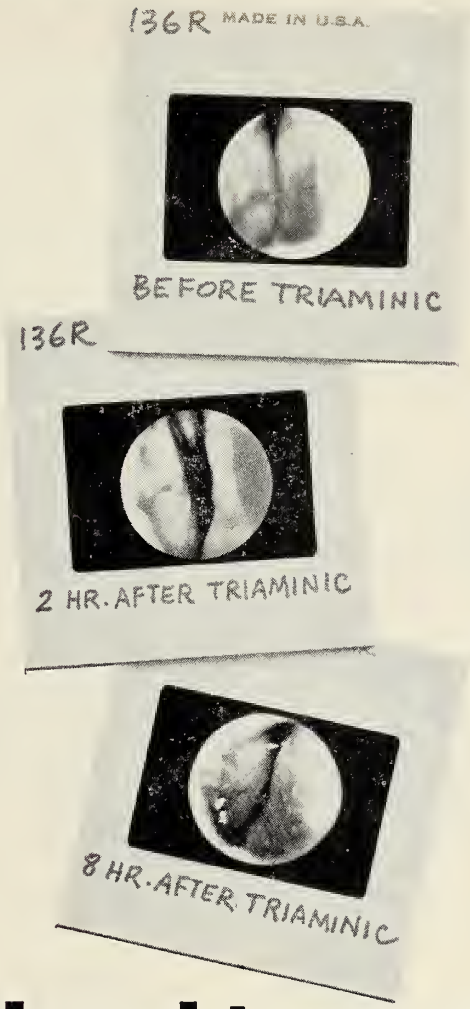
OEO TO TRAIN WOMEN FOR HEALTH CAREERS

Two hundred young Detroit area women from deprived backgrounds will have an opportunity to prepare for jobs in health-related fields as part of a special Women's Job Corps Project in Detroit.

Made possible by an Office of Economic Opportunity grant of $463,114 to the United States Public Health Service, the Women's Job Corps one-year project will train the young women (aged 17 to 21) in groups of 50 at a time for a three-month period. Basic education, vocational training, health education, and medical and dental care are all a part of the program. During the three-month training phase, the participants will receive board, clothing, and a living allowance.

The vocational training will be centered in the hospital environment.

From a continuing study on nasal congestion . . .



timed to work while your patient does

A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

Begun in March 1966, the study to date has encompassed 85 patients with common nasal disorders—and measured their response to recommended doses of Triaminic tablets.

Timed to release its oral nasal decongestant and two antihistamines within 8 hours, Triaminic was found to effect partial or complete relief in better than 82% of the subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic *really* works.

Triaminic® *timed-release tablets*

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride .... 50mg. Pyrilamine maleate........... 25mg. Pheniramine maleate........... 25mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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about doctors and their friends

James E. Harryman, m.d., Muskegon, presented a paper at the World Congress of Gynecology and Obstetrics in September. Entitled "Criminal Abortion and Air Embolism: A Cause of Maternal Death," background for the paper was gathered by the MSMS Maternal Health Committee in cooperation with the Michigan Department of Public Health. William W. Jack, M.D., Grand Rapids; Tommy N. Evans, M.D., Detroit; and Herman A. Ziel, Jr., M.D., Lansing, prepared the paper.

After nearly 25 years of dedicated service as director of Alumni Relations at Wayne State University, Homer D. Strong, Pontiac, at his own request, is resigning that position. Mr. Strong has been assigned other duties in the area of University Relations.

Paul W. Sundin, m.d., is now the director of the Monroe County Health Department. He is succeeding C. D. Barrett, M.D., who retired. Doctor Sundin recently received his master's degree in public health at the University of Michigan Public Health School. He formerly spent nine years in Decatur in private practice.

The winner of the American Academy of Pediatrics Aldrich Award in Child Development, Lawrence K. Frank, of Boston, received his law degree from Wayne State University. He was cited for his work with foundations in establishing child development research centers in the nation.

Wayne State University School of Medicine's James Holden Fellowship in Surgery has been awarded to Roger F. McNeill, m.d. Doctor McNeill will spend three months at WSU teaching and doing research in surgery.

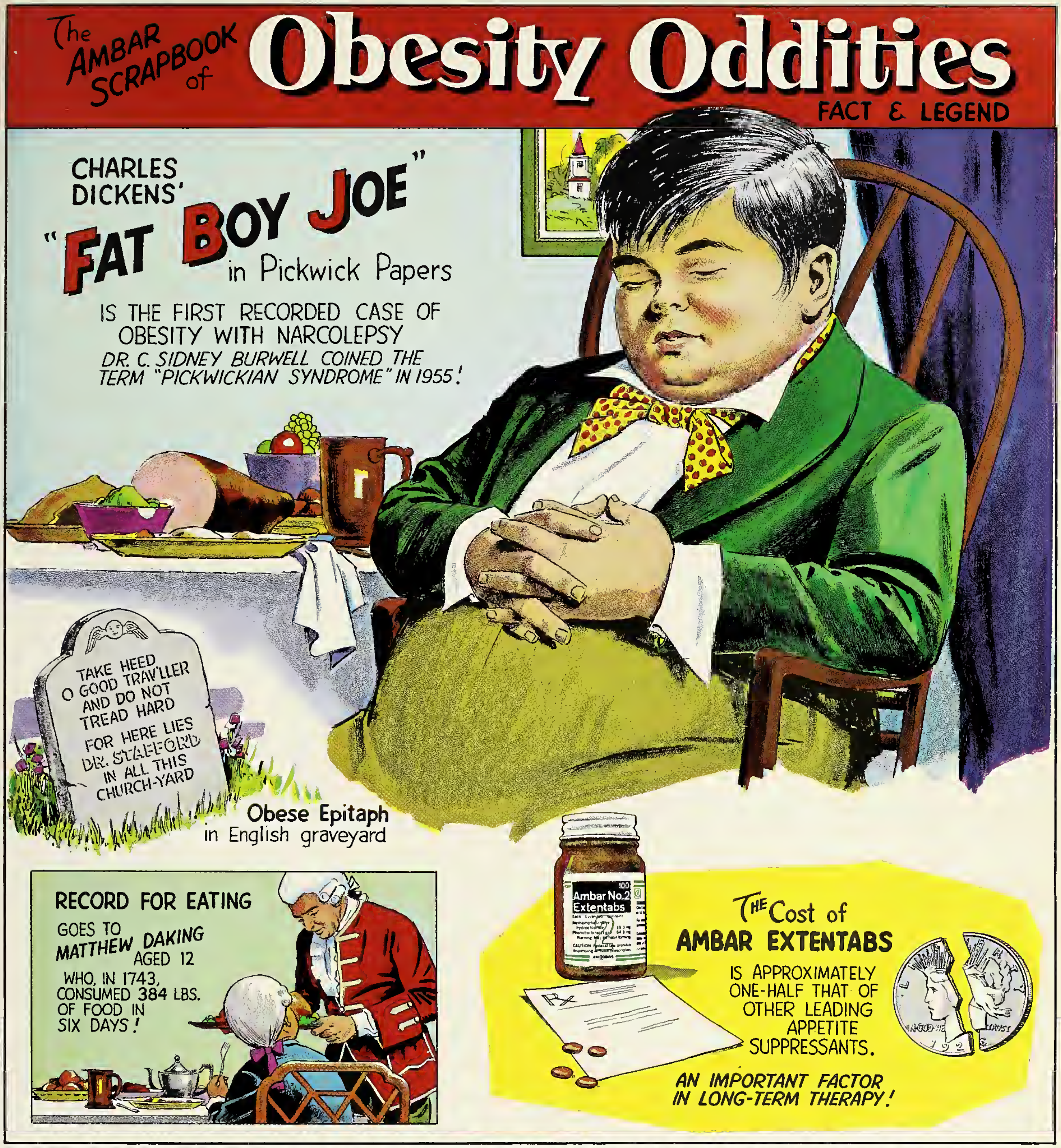
David W. Fricke, m.d., member of the Kent County Medical Society, is serving as a Volunteer assigned to Afghanistan. His wife, Mrs. E. Beryl Fricke, and family will join him after the birth of their second child in Philadelphia, expected in early November.

Doctor Fricke will be teaching surgery at the Nangrahar University Medical School in Jalalabad, Afghanistan.

Serving as a panel member for the meeting of the Detroit Branch of the American Urological Association, Inc., in September, was Yoshikazu Morita, m.d., of Wayne State University Medical School. Doctor Morita participated in the panel on "Management of Advanced Renal Failure."

William R. Ebert, ph.d., was recently appointed vice president of research and product development of Alliance Laboratories, Inc. Doctor Ebert, a registered pharmacist in Michigan, received his B.S., M.S., and Ph.D., degrees from the University of Michigan.

The LeMire family of Escanaba is continuing its tradition of medical service with John R. LeMire, m.d., opening a practice of general surgery. Having finished his internship and residency, Doctor LeMire is setting up his own practice in the offices of his father, William A. LeMire, m.d., and his uncle, Donald F. LeMire, m.d. Doctor John LeMire is in the third generation of LeMire physicians to practice in Escanaba. His grandfather, William A. LeMire, m.d., practiced medicine in that city from 1901 until his death in 1931. Doctor John LeMire's brother William III is also a physician and is presently doing his military service. He expects to return to Escanaba in July 1968.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BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

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in sinusitis, colds, U.R.I.

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up to 10-12 hours clear breathing on one tablet

Tons of Concrete and Steel Adding New Buildings at Three Medical Schools

Michigan's three medical schools are in a period of expansion designed to meet the present and future medical needs of the state. Following are statements of the construction plans for Wayne State University, the University of Michigan, and Michigan State University, and what this construction will mean in terms of medical school enrollment.

At all three schools some construction and renovation is underway; some is planned. Some financing is already obtained through various grants; some is still being sought.

Michigan Medicine appreciates the cooperation of the medical schools and the news departments in providing the following progress reports for MSMS members.

UNIVERSITY OF MICHIGAN

ANN ARBOR — Contractors at the University of Michigan Medical Center are pushing ahead on nearly $25 million worth of new construction projects.

They include the $12.5 million Medical Science Building Unit II; the $8 million C. S. Mott Children's Hospital; the University's largest parking structure, a $3.2 million facility, and the $1.5 million Center for Continuing Medical Education.

In addition, there is substantial remodeling underway in the University Hospital, and construction is expected to begin next spring on the $1 million Upjohn Center for Clinical Pharmacology.

Construction crews are "topping out" the seven-level new Medical Science II building, hoping to "close in" the exterior and roof by Feb. 1. Estimated completion date has moved from May 1968 to December 1968. The reinforced-concrete and brick structure will be tied directly to the west side of Medical Science I on Catherine Street.

"WHEN COMPLETED, we will have all of our medical students here at the Medical Center for the first time," says Associate Dean Alexander Barry of the Medical School. The research and teaching building will put all of the school in one physical area for the first time in three-quarters of a century. The basic science departments will be moved out of the old East Medical building on the central campus. Moving in with the departments of anatomy, physiology and microbiology will be the department of human genetics.

A concept of sharing laboratories by the anatomy and microbiology departments has been developed for more effective utilization of space in the new building," points out Dean Barry. "With this dual capacity, we will make the maximum use of laboratory facilities that is compatible with efficient teaching."

There will be 158,000 square feet of usable space, with a staff of some 480 persons, including faculty, technicians, and secretaries. The new building's design features a semi-circular projection westward. This area will contain three large, identical lecture rooms, accommodating about 270 students each. Departmentally-assigned research facilities totaling nearly 100,000 square feet of space are to be located in the south wing.

Financed by $9.4 million from the state and $2.5 million from the federal government, the new building will house part of the anatomy department on the third level (grade level) to the north, and human genetics in the south portion (facing the Buhl Research Center for Human Genetics). The Animal Care Facility will be located on the second level. Anatomy and human genetics will comprise the fourth level, with anatomy and microbiology on the fifth level. Microbiology and some physiology facilities will be located on the sixth level and the seventh level will have more physiology department laboratories.

The new Medical Science building will be equipped for closed-circuit television in all laboratories and lecture rooms. Expansion of the present system will make the U-M Medical School one of the first in the country to offer students closed-circuit color television instructional facilities.

THE EIGHT-FLOOR MOTT Children's Hospital is scheduled for completion by December 1968. The building for the clinical care and treatment of children was financed by grants totaling $6.5 million from the C. S. Mott Foundation, *Flint*, and a federal government Hill-Burton grant of $661,915.

The 200-bed hospital will contain administration and laboratories on the second level, operating rooms and radiology, third level; and the fourth through seventh levels will be patient floors. The eighth floor will house the school, workshop and playrooms for convalescing youngsters. These have been provided on the upper floors of the Main University Hospital. The new facilities will be equipped and furnished by the Galens Honorary Medical Society, the Michigan Kiwanis Clubs and others.

The new hospital is being constructed between Women's Hospital and the Outpatient Building.

JUST EAST OF the Mott Hospital, is the new Center for Continuing Medical Education. This two-story building will house the Medical School's department of postgraduate medicine, serving physicians throughout the state. The building, containing 41,000 square feet of space, is scheduled for completion in October 1968. It will connect to the Mott Children's and main hospitals by an east-west pedestrian service corridor.

Nearly complete at the southeast corner of the Medical Center is the new parking structure. Its 351,000 square feet will provide parking for 1050 cars. Basic structure work is completed and workers are finishing masonry and mechanical-electrical installations. It is to be ready for use by Nov. 1 of this year.

NEEDED: FULL SPEED AHEAD

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL:

- Medical Science (Unit II)
- Mott Children's Hospital
- Continuing Medical Education Center
- Upjohn Center for Clinical Pharmacology
- Parking Structure

WAYNE STATE UNIVERSITY MEDICAL SCHOOL:

- Basic Science
- Medical Library
- Outpatient Clinic
- Conference Center
- Vivarium
- Parking Structures

MSU COLLEGE OF HUMAN MEDICINE:

- Life Science

Remodeling in the main hospital includes installation of air conditioning in the surgical and other areas. Construction will begin in early 1968 on a $1.5 million elevator project.

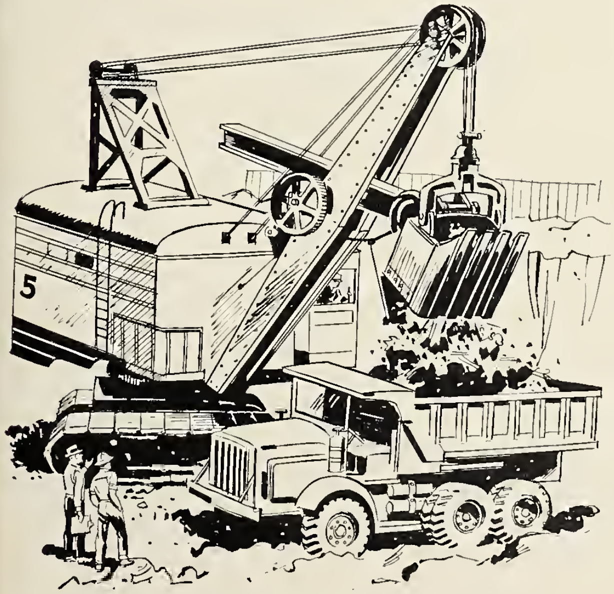
Four high-speed automatic passenger elevators and a service elevator will be located in the main hospital corridor. A new ambulance entrance court is to be built to the west, with service on the third instead of second level, accessible by ramp. Also new northeast and southeast fire stairways will be added, tying in at all levels.

FINAL PLANS ARE expected to be approved by early 1968 for the nation's first research and training center devoted to clinical pharmacology. The University is currently seeking federal funds to match a $1 million gift from the Upjohn Company of Kalamazoo for the facility, which will train physicians and provide a base for patient care related to research and training. Plans incorporate expanding the building either before or after construction has begun, with construction to be completed by late 1969.

* * *

WAYNE STATE UNIVERSITY

DETROIT — Federal support for Wayne State University's Basic Science Building on its new medical campus in the Detroit Medical Center now totals $11,677,000. The funds from the United States Public Health Service have come in two grants, one for $4,677,000 awarded last September for research facilities and the award of $7 million for teaching facilities announced on May 9 of this year.



University President William R. Keast states that each grant, at the time of announcement, was the largest ever received by Wayne State University and both rank among the largest awarded by the United States Public Health Service to any organization or institution.

Total cost of the Basic Science Building will be $23.5 million. The University is looking to the State of Michigan for the rest of the funds needed for the new teaching facility, states Dean Ernest Gardner, M.D., of the School of Medicine.

"THE UNIVERSITY has had a $12 million item in its capital budget for several years as the State's share of support for the Basic Science Building. A preliminary allotment of $500,000 has already been made and another $2 million is included in the proposed 1967-1968 budget."

Doctor Gardner points out that the concept of the WSU medical school's new campus and its integration in the Detroit Medical Center is largely the work of Gordon H. Scott, Ph.D., University vice president for medical school development.

Ground breaking for the Basic Science Building is anticipated for next autumn. Upon completion, the new teaching structure will allow an increase in the entering class of medical students from 125 to 200.

The eight-story building will be located just west of the WSU Medical Research Building, which was completed in 1964 at a cost of $4 million, and directly across Brush Street from Grace and Harper Hospitals. It will house six of the medical school's 25 departments — anatomy, physiology, pharmacology, biochemistry, microbiology, and pathology — as well as administrative and service facilities. Floor space will total just under half a million square feet. Architects are Giffels & Rosetti, Inc., Detroit, and John Williams Associates, Cleveland.

In addition to the research areas and two-story lecture halls, the teaching facility will contain 32 multi-discipline laboratories, each designed to serve as 'home base' for 16 students. Instead of students moving from room to room, the professors will do the moving to conduct their classes.

Student study areas will include sections equipped with calculators, typewriters and fixed microscopes. Television facilities will be located on the first floor. Equipment for closed circuit television will provide a relay point for televising from area hospitals to any or all students attending classes in the building. Another feature will be an input, output satellite station to serve as a branch of the computing center on the WSU main campus.

PLANS FOR the School of Medicine also call for a $2 million medical library, an outpatient clinic capable of serving 250,000 patients a year, a conference center, a vivarium, and parking structures.

Total cost of the new medical campus, covering some 25 acres is estimated at $56 million for land, present and proposed buildings.

* * *

MICHIGAN STATE UNIVERSITY

EAST LANSING — Having just completed a $1 million renovation of its basic medical science building, Michigan State University is requesting state and federal support to construct a $9.6 million Life Sciences Building. The University has already received $625,000 from the Kellogg Foundation in support of the construction.

The Life Sciences Building will help MSU's new medical school, now beginning its second year of operation, expand its entering classes from 26 to 64 students, and provide for similar enrollment expansion in the nursing and pharmacology programs.

THE BUILDING WILL house teaching and research laboratories for the Department of Medicine, the Department of Pharmacology, and the School of Nursing, and offices for the deans of the College of Human Medicine and the College of Veterinary Medicine.

In addition to $9.6 million for the building proper, it will cost an estimated $1.8 million to provide utilities and otherwise develop a new site which can then be used for construction of additional medical buildings. The site is south of the present campus and just west of Hagadorn Road.

The building, which is eligible for matching funds from the National Institutes of Health, is vital to MSU's nursing and pharmacology programs as well as to the present basic medical program.

Assurance of two additional buildings would be needed before MSU could proceed to the full medical degree-granting status which the State Board of Education recommended to the governor and the legislature in January.

One of these buildings would provide teaching and research facilities for clinical departments. The other would be a teaching hospital-outpatient clinic of about 300 beds. This is relatively small for a medical center because MSU plans to make maximum use of community hospitals and other clinical resources if the full program is funded.

Teaching facilities for new medical school buildings are eligible for two-to-one matching funds.

AT PRESENT, the basic building for the College of Human Medicine, the College of Veterinary Medicine and the School of Medical Technology is Giltner Hall, which was recently renovated at a cost of $1 million.

A total of 115 rooms, mostly laboratories and office laboratories, were remodeled and the heating, ventilating and electrical systems were overhauled.

Space in the building became available when the Veterinary Clinic moved to a new building on the south campus. Renovation has permitted expansion of teaching and research capabilities of the Departments of Anatomy, Microbiology, Pathology, Physicology, and Pharmacology, in keeping with development of the medical program and growth of the veterinary program.

Another key building for the College of Human Medicine is the $5.2 million Biochemistry Building, which was completed in 1965 and is one of the nation's leading facilities for biochemical research and teaching.

Medical Guide

in chronic illness

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Vitamin B_1 (as Thiamine Mononitrate)	10 mg
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Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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STRESSCAPS

SPECIAL ARTICLE

MDs Concerned Because Quackery Delay Proper Care That May Cost Life Itself

BY H. DOYL TAYLOR, LL.B.
DIRECTOR, DEPARTMENT OF INVESTIGATION
AMERICAN MEDICAL ASSOCIATION

EDITOR'S NOTE:

This article is excerpted from an address by Mr. Taylor at the Medical Quackery Workshop at Ball State University, Muncie, Indiana.

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Private American citizens spend $24.8 billion dollars in a year for health care — how much goes to quacks?

The estimates are at best calculated guesses, but the most-often quoted figure is a billion dollars a year.

That figure is quoted most often by governmental spokesmen, who admit it includes only those quackery schemes in which the U.S. has a direct interest — in other words, those involving interstate commerce. We suspect that another billion dollars is spent for worthless health care on an intrastate basis.

> At any rate, the monetary cost of quackery far exceeds the entire cost of health education, plus the entire cost of all medical research in this country.

It is this cost of life — and health — that has placed America's doctors of medicine in the front lines of the war on quacks. It is the insidious side effect of quackery with which medicine concerns itself — the delay in proper medical care that may cost life itself.

IT IS FOR THIS reason, too, that the medical profession is dedicated to education of the people about cultism — chiropractic and the other health sects that turn their backs on scientific medicine. The House of Delegates of the AMA said in 1933:

> "Either the theories and practices of scientific medicine are right and those of the cultists are wrong, or the theories and practices of the cultists are right and those of scientific medicine are wrong."

And, in 1961, the AMA House said:

> "There can never be a majority party and a minority party in any science."

There's another quote from the Proceedings of an AMA Convention that I'd like to read to you.

> "Physicians, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms."

That quote is from Proceedings of the AMA Clinical Convention in Philadelphia in 1847!

QUACKERY HAS BEEN variously defined, but there probably isn't a better definition than that "quackery is the pretension or practice of a boastful pretender to skill which he does not possess, especially medical skill."

Dorland's Medical Dictionary defines a quack as "one who fraudulently represents his ability and experience in the diagnosis and treatment of disease, or the effects to be achieved by the treatment he offers."

Black's legal dictionary defines fraudulent as "a generic term embracing all multifarious means which human ingenuity can devise which are resorted to by one individual to get advantage over another by false suggestions or by suppression of truth."

Thus, a fraudulent act may be a sin of commission or a sin of omission.

QUACKERY EXISTS because the public permits it to exist, in some instances openly fostering its practice and growth.

Theories regarding the motives that prompt people to patronize quackery are as numerous as the quacks themselves. Most authorities agree, however, that the basic root of these motives is fear. Of all earth's creatures, only man is aware of the fact that someday he must die.

The average man wants life, he wants it more abundantly, and he wants it now! When this life is threatened or seems in danger of ending through sickness or disease, the drive for self-preservation causes the sufferer to seek a cure — any cure.

Through faddism, fraud, deception and delusion, the unknowing are led to seek non-existent shortcuts to health. Knowing only what they're told by these super-salesmen, millions of persons each year attempt self-medication for self-diagnosed symptoms. Others, some with confirmed illnesses, are beguiled with assurance of a quick cure . . . even for incurable diseases. Medicine can't always give such assurances. The quack, unhindered by ethics or concern, can.

QUACKERY CAN NEGATE the good that medicine can do. It can steal precious time — that early period of a disease when prompt, efficient treatment can often mark the difference between life and death. The cancer patient who infuses himself with expensive sure-fire cures — ranging from seawater to alleged new "drugs," is in reality only withholding from himself surgery, chemotherapy or radiation that might arrest the disease.

Quackery also can mask disease symptoms with telling effect. The non-prescription potion that soothes a persistent stomach upset may serve only to delay a trip to the doctor by a man with an unknown ulcer — a delay that often fosters serious consequences.

Quackery is more than just quacks themselves. It includes, to name just a few of the broad areas, the use of unproven drugs, worthless devices and treatment regimens.

SPOTTING THE QUACK

How can a quack be spotted?

There are six simple indicators:

1. **He uses a special or "secret" formula or machine that he claims can cure disease.**
2. **He promises a quick or easy cure.**
3. **He advertises, using "case histories" or testimonials to impress people.**
4. **Refusing to accept the tried and proven methods of medical research and proof, he clamors constantly for "medical investigation" and recognition.**
5. **He claims medical men are persecuting him or that they are afraid of his competition.**
6. **He claims that his method of treatment is better than surgery, X-rays or drugs.**

All of these areas fall within the purview of the Department of Investigation of the AMA. Many of the drugs claim effectiveness in two of the most fertile fields for quackery — cancer and arthritis.

Then there are devices — a fertile field for quackery since time began. George Washington, for example, once bought a pair of metallic tractors — simple rods — that were supposed to draw out disease and illness.

THEN, THERE'S literature and advertising. Topics pertaining to health and medicine have attracted a growing number of American readers in recent years. The increase in books, magazine articles and newspaper columns published on health matters is truly amazing. Some of these books and articles, however, present spurious health information, or information that at best must be considered questionable. It is this portion of published materials, even though it is small in relation to the total output, that is of concern to the doctors of medicine.

The Journal of the American Medical Association in 1965 reprinted an article from an earlier issue (September 25, 1964) of *Science* magazine on how to distinguish "between crackpot work and good science" in published material. The article was titled, "A Measure for Crackpots," and the author, F. J. Gruenberger, outlined a "checklist" to which he had assigned point values totaling 100 for weighing the worthwhile attributes of published articles.

This "checklist" may help you in your own evaluation. The thirteen items to be checked are:

1. PUBLIC VERIFIABILITY: 12 POINTS. — The scientist says, "I did thus and so and observed its effect; you are free to repeat my steps." The crackpot often says, "This is revealed truth; sorry,

but I and my followers are the only ones who can obtain these results."

2. PREDICTABILITY: 12 POINTS.—To what extent can the technique or "science" being advocated be applied to the future. When a man can predict, and the predictions turn out to be true, a great deal has been gained toward credibility.

3. CONTROLLED EXPERIMENTS: 13 POINTS.—This item has been assigned the greatest weight on the list. The scientist seeks to devise controlled experiments if he can. The crackpot, on the other hand, often seeks to avoid controlled experiments, or, if some are performed, he may invent marvelous excuses to explain why they did not bear out his theories.

4. OCCAM'S RAZOR: 5 POINTS.—This is the principle that, of two possible explanations for the same phenomenon, scientists prefer the simpler. In other words, the one with the fewest hypotheses. It is not a stringent test, but it is a point to consider.

5. FRUITFULNESS: 10 POINTS. — Fruitful in this concept means an ability to suggest new ideas — new approaches and new tests — rather than practical or material results. The argument is that the more scientific a subject is, the more it tends to lead to "fruitful" results.

6. AUTHORITY: 10 POINTS.—Weight of authority tells. Among scientists, it is equivalent to building up credit. Each new subject that claims the mantle of science is supposed to be submitted immediately to known and recognized scientists for both opinion and test.

7. ABILITY TO COMMUNICATE: 8 POINTS.—Most scientists soon discipline themselves in accepted methods of communication with their colleagues, their cohorts, and the public. The crackpot scorns accepted channels.

8. OPEN-MINDEDNESS: 5 POINTS. — This test as a discriminator is not strong. Some persons judged in time to be true scientists were stubborn and pigheaded in their early days. In general, however, the scientist tends to use such phrases as "It appears that . . ." and "It would seem plausible . . . ." The crackpot is generally dogmatic and arbitrary.

9. HUMILITY: 5 POINTS.—This is a minor point, perhaps, but we expect a scientist to tend toward humility. To be sure, there are (and will be) arrogant scientists; we try to forgive them, but the very act of forgiving implies that the test exists.

10. FULTON NON SEQUITUR: 5 points.—This is a negative test. The true crackpot can frequently be spotted on this test alone. He argues, "They laughed at Fulton. He was right. They're laughing at me. Therefore, I must be an equal genius."

11. PARANOIA: 5 POINTS.—This is another negative test. Lack of paranoia characteristics earns the points. Again, the crackpot may sometimes be spotted on this test alone.

12. DOLLAR COMPLEX: 5 POINTS.—This is another negative test. The crackpot almost always is overly impressed with the value of his discoveries — they're earth-shaking. While this test is somewhat related to the humility aspect, it is different enough to rate its own five points.

13. STATISTICS COMPULSION: 5 POINTS. — It seems to be a characteristic of crackpot literature that statistics are not only used but continuously explained. The crackpot is fascinated to discover that a coin tossed 1,000 times doesn't necessarily fall heads 500 times. He is compelled to tell the reader — sometimes on every page — the probability of having 523 heads. The scientist who knows his statistics generally assumes that his reader is informed. He seldom ends the sentence with an exclamation point.

This "checklist" is not meant to be an absolute guide. It merely offers 13 items that an author-scientist thought worthy of weighing in order to form a judgment on whether the book or article is the work of a scientist or of an off-target crackpot.

THE HEALTH QUACK is not so easy to spot these days. The stovepipe hat and the pitchman's hawking have gone. In their place are their space-age counterparts, the suave, apparently-sophisticated super-salesmen with the Madison Avenue manners.

These merchants of menace, more insidious and unscrupulous than ever, have many new products, worthless diet fads, worthless food supplements, worthless cosmetic devices and treatments such as the all-purpose spinal adjustment, worthless "cures" for everything — even into the area of the brain-damaged children and other mental illness.

They bilk the undiscerning — the uninformed, the desperate, the unsuspecting of all ages — of millions and millions of dollars a year, even in this year of great intellectual enlightenment.

From its very inception 120 years ago, the AMA has been battling quackery, and it is dedicated to a continuation of this warfare against wasting the nation's health and its health care dollar . . . of fighting fraud at the bedside of ill and desperate people.

For, as long as there are human beings, there will be human nature . . . and quacks — pretenders to ability they don't possess — to take advantage of the fact.

A Building Block approach to treating hypertension

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With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .

Pargyline Hydrochloride
220
200
180
160
140
120
100
80
Deserpidine
Methyclothiazide

Consider starting your hypertensives on this basic thiazide

ABBOTT

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

ENDURON
ENDURON
METHYCLO THIAZIDE
2.5 mg.
Methyclothiazide

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE

DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

ABBOTT

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!

Deserpidine
Methyclothiazide

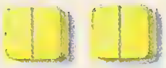
Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	 10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

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Eutonyl affords a different kind of basic therapy for moderate to severe cases

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

EUTONYL®
PARGYLINE HYDROCHLORIDE
EUTONYL®
25 PARGYLINE HYDROCHLORIDE
EUTONYL®
50 PARGYLINE HYDROCHLORIDE
Pargyline Hydrochloride

Once a day, every day

EUTONYL®

PARGYLINE HYDROCHLORIDE

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

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1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

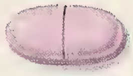
Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.

EUTRON
Methyclothiazide
Pargyline Hydrochloride

Once a day, every day

EUTRON™

**PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.**

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE				
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

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ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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SYMPOSIUM ON TRAUMA IN DETROIT, DEC. 6-7

The "Team Approach in a Disaster Area" will be one of the topics for the 15th Annual Symposium on Trauma, primarily sponsored by the Detroit Chapter of the Michigan Committee on Trauma of the American College of Surgeons, at the Wayne County Medical Society Building, December 6 and 7.

This year the symposium will be held in conjunction with Wayne State University's Centennial celebration and will run for two days instead of one.

There will be several panel discussions. Alexander J. Walt, M.D., professor of surgery at Wayne State University School of Medicine, will chair the panel on "The Team Approach in a Disaster Area."

William A. Lange, M.D., Wayne State's Department of Plastic Surgery, will lead a panel on "The Handling of Wounds and Their Repair;" Joseph L. Ponka, M.D., chief of the Fourth Surgery Division, Henry Ford Hospital, Detroit, will chair a discussion on "The Emergency Room;" and Clifford D. Benson, M.D., chief of surgery at Children's Hospital, Detroit, will lead a panel on "Trauma and Children."

Some of the presentations to be made during the symposium are as follows: "Injuries of the Hand," to be discussed by Joseph L. Posch, M.D., associate clinical professor of surgery at Wayne State, and by Robert D. Larsen, M.D., Assistant Clinical Professor of Surgery, also at Wayne State; "Head Injuries," to be discussed by E. S. Gurdjian, M.D., from the Department of Surgery at Wayne State, and L. Murray Thomas, M.D., Department of Neurosurgery at Wayne State.

A discussion of "Organ Failure in Trauma" will also take place during the symposium. Featured speaker on "Liver Failure in Trauma" will be Theodore Drapanef, M.D., Professor of Surgery from the University of Pittsburgh Medical School.

The Trauma Symposium will run from 9:00 a.m. to 5:00 p.m. each day.

For further information and registration contact: Joseph L. Posch, M.D., general chairman, 1408 Kales Bldg., Detroit, 48226. Tel. (313) WO 2-1066.

Accepting the 1967 Blue Shield "Emmy" award at the Michigan State Medical Assistants Society annual meeting is Mrs. Alta Greene, MSMAS immediate past president. Blue Shield Professional Relations Director Neal McCue presented the annual award to Mrs. Greene in recognition of her leadership of the organization during the past year. Looking on is Helen Schick, center, Blue Shield's educational coordinator. Mrs. Greene is assistant to R. A. Stiefel, M.D., Battle Creek.

Medical Genetics Seminar Nov. 27-30 Offered by ACP at U-M

The American College of Physicians will present a four day seminar, November 27-30, on Medical Genetics in the Medical Science Building at the University of Michigan Medical Center.

Formal lectures each day will give special attention to such diverse areas as hereditary syndromes, the hemolytic anemias, cytogenetics, population genetics, and applications of computers will also be discussed. Participants will break up into small workshop groups after each talk.

Several guest lecturers will join the U-M faculty in making the presentations. They are: Alexander G. Bearn, M.D., Professor in the Department of Medicine, Cornell University Medical School; Barton Childs, M.D., Professor in the Department of Pediatrics, Johns Hopkins University Medical School; John B. Graham, M.D., Professor in the Department of Pathology, University of North Carolina School of Medicine; Arno G. Motulsky, M.D., Professor in the Department of Medicine, University of Washington Medical School; and Margery W. Shaw, M.D., Associate Professor, Department of Biology, University of Texas Graduate School of Biomedical Sciences.

For further information contact: Edward C. Rosenow, Jr., M.D., F.A.C.P. Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

SEES SIX PROBLEMS IN SUCCESSFUL HEART, CANCER, STROKE PROGRAMS

The No. 1 problem in the Heart, Cancer, Stroke project is in the field of communication.

That statement was made by James T. Howell, M.D., Detroit, in a recent issue of *Michigan Hospitals*, the monthly publication of the Michigan Hospital Association. Doctor Howell, director of the Henry Ford Hospital, is a member of the National Committee on Heart, Cancer and Stroke.

In an overview article about Public Law 89-239, Doctor Howell wrote:

"To me the largest single problem is in the field of communication.

"How to involve all of the persons who must ultimately figure in the team play will tax the ingenuity of all of us as the program penetrates from its source of origin throughout each community.

"These communicative problems will then become organizational problems as regional programs unfold.

"The second question appears to be one of finding the handle so that planning can be seized and then wielded.

"The magnitude of medical problems in the community, as well as their complexity, breeds some inescapable confusion.

"Cooperation is the third problem. Yes, there are some traditions in each of our areas which will need some disturbing, if regional plans are to develop, recognizing the inherent difficulties in the simple word "change."

"There are some who will not agree with the concepts of the law at all. There will be those who will simply wait and watch. There will be ones who doubt than an organization can be accomplished which would include so many, and so many varied, participants. But there will be, I am sure, a winning core who will look at the value to patient care that might be received, and who will bring wise weight to bear on cooperative progress.

"Fourth, there is some question about the definition of research in regional medical programs; but if we keep patient-care administration uppermost in our considerations, then conflict with other research efforts, including the categorical institutes of the National Institutes of Health, then this problem should not be defeating.

"A fifth area which we should consider is geographic overlapping or gapping between regions. The National Advisory Council must be

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decisive about regions of the country that have been either overlapped or left out of programming.

"The final problem I would say a word about is planning content and its evaluation. Hopefully, the successful regional programs can be promoted so that the level of effectiveness can be spread to others, being mindful of the differences in local needs.

"Perhaps the real problems will fall upon those who must study and make judgments about the levels of attainment within each regional program, and to this end I would assure you that within the national program we are studying the components of effective programs and their measurement."

Swisher Sees Changes In Society Challenging Medical Education

Increasing public demand for adequate health care for all people is creating many challenges today for medical education.

That contention was voiced by Scott N. Swisher, Jr., M.D., chairman of Michigan State University Department of Medicine, recently in an address on the Spartan campus.

The American physician today, he said, faces an increasing conflict between the tradition of a single-patient, individualized, focus of responsibility and increasing pressure to assume certain patient-group oriented responsibilities.

Doctor Swisher presented this example:

"Should he (the physician) see Mrs. X who depends upon him for a great deal of psychological support in facing a difficult life situation, or should he participate in an infectious disease screening clinic for migrant workers? If he can't do both, chances are he will care first for the patient for whom he has long term personal responsibility, even though, I might point out, it may be a difficult, stressful and economically unrewarding experience. But he, and some day you (the medical student), will have to make such choices more frequently."

"Society," the MSU medical professor said, "is just beginning to recognize poverty as a cultural phenomenon rather than in strictly economic terms." Physicians, he added, must help to clarify the important difference.

"We still have a powerful command of the public's attention; witness the effect of several physicians' recent testimony before the Congress that there is starvation in this country, a fact well known to many public officials and welfare workers for a long time," said Doctor Swisher.

WHAT IS

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WE GET LETTERS! STUDENTS PLEA FOR HELP WHEN PAPERS DUE

The Medical Society receives requests for many kinds of information.

Sometimes it is from a patient who wishes information about a certain disease he or a member of his family might have. Sometimes a librarian asks a question. Sometimes a school counselor requests materials, but the large majority of requests come from young people, many of whom are concerned with a career in the health field or with completing a term paper.

Included here is a selection of such letters.

"I am interested in medical working. I am in the process of collecting some information of this occupation . . . ."

"I'm doing a research-notebook on vocations, so I chose nursing. I would be very grateful if you could send me some type of *information* on nursing (*Pamphelts*, folders anything really!) Maybe you could write me some *information* from your own opinion and experience. If you are able. Please send it as quickly as possible as my notebook is due in two weeks. I need your help!!!"

"I would appreciate any information you could send me on doctoring or medicine as I need this information for a term paper which is due in three weeks . . . ."

"I am a high school student and am writing a term paper for this semester. I would like you to send me some information on this if it can be arranged." (This young writer neglected to say just what her subject was!)

"For my 9th grade Civics class I am writing a term paper on 'Medicine.' Please send to me any information you have that might help me."

"I am writing in request for the free information you have to offer. I am obtaining this information for a vocational class in school. Please send to this address."

"Our freshman high school class is studying vocations. I am writing in request of any information you might have concerning medicine. If you do please send it to me. Please hurry only five weeks of school left."

"I plan to make my future career medicine. As of now I am only 14 years old and in 9th grade and also a bit puzzled on what type of medicine I should like to attempt to make my career. Could you possibly send me material if it wouldn't be much bother. I would appreciate very much all the help I can possibly get."

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A non-profit foundation

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Member, Michigan Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

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Dear Doctor:

Wouldn't you like your patients to learn more about the contributions made by the world of medicine to their welfare? So that they can better appreciate the efforts of the health team to keep them in good health?

To tell the stories of medical and pharmaceutical advances to people throughout the country, the Pharmaceutical Manufacturers Association is sponsoring a unique "magazine within a magazine." It is called *Medicines and your family's health* and the first issue appears in the November *Reader's Digest.*

We would like to send you 50 free reprints of *Medicines and your family's health* for use in your reception room. Your patients will find the articles in this issue factual, educational and of immediate personal interest.

Just fill out the coupon below and send it to us.

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Why have many dread diseases vanished? . . . What's in a drug name? . . . What are the drugs that reach troubled minds? . . . Where are prescription drug prices going?

Medicines and your family's health

2 4 6 8

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What Ever Became of Those Quarantine Signs?
The Anonymous Drug That Hospitalized a Patient
Medicines for the Troubled Mind
How Does the Price of Medicine Compare with Other Prices?

Reprinted from the November, 1967 issue of The Reader's Digest

SWAN, NMA PRESIDENT, CONCERNED ABOUT NEED FOR HEALTH WORKERS

(Editor's Note: Following are some excerpts from the acceptance speech of Lionel F. Swan, M.D., Detroit, new president of the National Medical Association, at the recent 1967 NMA convention.)

"I call on the doctors of America to solve the health problems in this country — and doctors can do it! What are some of the major health problems in the American environment in 1967?

"One: Discrimination against and segregation of Negro patients.

"Two: Discrimination against Negro physicians.

"Three: Discrimination against family physicians.

"Four: Fragmented, impersonal, and inadequate health care of the poor.

"And five: Shortage of health personnel.

"The National Medical Association calls upon doctors to help solve these problems. If every physician throughout this country — white, black, Republican, Democrat, Socialist, Communist, right-winger, left-winger — if every physician would say to his hospital tomorrow, "I will no longer work in a hospital which discriminates against or segregates any human being for any reason, other than health considerations," discrimination and segregation would be ended tomorrow afternoon. If every such doctor said to his hospital board of trustees, "I refuse to work in a hospital where doctors are denied admission because of race or color," this type of discrimination and segregation would be ended tomorrow afternoon — or as soon thereafter as the board can meet.

"I want to give notice that the National Medical Association in conjunction with other civil rights organizations will continue to fight with all its resources against all health institutions and facilities that discriminate against Negro physicians and their patients. Let the racists know that as long as they continue this nefarious practice, they will have no peace. They will have to go from court to court. They will have to travel to Washington to defend their right to federal funds. And I assure them, they will get tired long before we will.

"I urge all physicians in full-facility hospitals to insist on the addition of a department of family practice so that family physicians may be drawn into full orbit of medical life.

"I urge all physicians to re-dedicate themselves to the proposition that good health care is the right — the inherent right — of every individual, not just a privileged few. For what greater right

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Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

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Battle Creek, Michigan

Serving Michigan Physicians

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Grand Rapids - Lansing - Muskegon - Saginaw - Traverse City

can a man have than the right to good health care? If he is entitled to life, liberty, and the pursuit of happiness, what is his life worth without good health? How can he be free if he is imprisoned by disease? How can he pursue happiness when he isn't healthy enough to run after it?

"I urge all physicians to collect through their local medical societies for distribution in their offices literature relative to opportunities in the health fields in one massive talent recruitment for medical personnel, and that we work closely through school counselors to recruit students into the health fields. Simultaneously, the lawmakers whom we help elect should be persuaded to make available the necessary funds for scholarship aid so that more personnel may be drawn into the health fields to care for all the people of our land."

S. L. BASS SUCCEEDS DOAN AS DOW CORNING CHAIRMAN

Shailer L. Bass is the new chairman of the board of Dow Corning, Midland. He succeeds Leland I. Doan and will continue as chief executive officer of the company. Mr. Bass joined Dow Corning in 1944 and invented the first commercial silicone product.

Dow Corning Corporation is the nation's largest producer of silicones. Founded in 1943, the company is an outgrowth of research in organosilicon chemistry by Corning Glass Works and the production know-how of The Dow Chemical Company. Dow Corning is an international organization employing over 3500 people. It operates facilities at Midland and Hemlock, Michigan; Greensboro, North Carolina; Trumbull, Connecticut; Elizabethtown, Kentucky; Carrollton, Kentucky; and Stamford, Connecticut.

William C. Goggin was named to succeed Mr. Bass as president. He joined Dow Chemical in 1936 and has filled various positions in the research, marketing, and plastics departments.

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keeps you informed
and helps pay for
publishing costs!

When the local
representative calls,
tell him you saw
his company's ad in
your journal.

DETROIT DOCTORS INVOLVED IN TOP MEDICAL FILM

A 16 mm animated color film, "Osteoporosis of Aging," has been released by Sandoz Pharmaceuticals. Recognition, diagnosis, and treatment of osteoporosis are the themes of the 18 minute film.

Judged the best medical film at this year's Columbus Film Festival, "Osteoporsis of Aging" is a report by Richmond W. Smith, Jr., M.D., Chairman of the Department of Medicine, in collaboration with Harold M. Frost, M.D., Chairman of the Department of Orthopedics, both of Henry Ford Hospital.

ANOTHER GRANT AIDS U-M HEARING RESEARCH

A Public Health Service grant of $246,852 has been awarded to the Kresge Hearing Research Institute at the University of Michigan to support a comprehensive, long-term investigation into the causes of deafness.

The 1967-68 grant covers the third year of a seven-year project grant totaling $1.5 million. It was awarded by the National Institute of Neurological Diseases and Blindness. The research made possible by this project grant is regarded as America's most concentrated current effort to probe hearing problems.

Who Was Dickinson?

Know your Michigan history?

Which county was the last to be organized?

It was Dickinson in the Upper Peninsula in 1891.

And who was Dickinson?

Don M. Dickinson distinguished himself as a member of the cabinet of President Grover Cleveland during Cleveland's first administration.

In 1891 the Democrats had control of the state legislature — and that was a rarity — and the legislators chose to honor Mr. Dickinson, one of their loyal Michigan workers.

If you are interested in "The History and Meaning of County Names in Michigan," you'll enjoy an article by that title written 1912 by W. L. Jenks in *Michigan Pioneers and Historical Collections,* XXXVIII, pages 439-478.

Beaumont Hospital, Wyandotte Chemicals Begin Research Project

In a unique collaboration between a basic industry and a community medical center, Wyandotte Chemicals Corporation has awarded a grant of $41,025 to the William Beaumont Hospital Research Institute for investigation of possible new medical uses for a promising line of chemical compounds.

It is hoped that the project will establish new pharmaceutical aids for better treatment of shock and certain conditions associated with heart surgery. Wyandotte Chemicals research leaders will work directly with scientists of the Beaumont Research Institute in advancing the study.

Beaumont principals in the project are Robert M. Nalbandian, M.D., consultant to the Research Institute and chairman of the Institute's Board of Governors, and Alan C. Hymes, M.D., a member of the surgical department at Beaumont Hospital and an active research scientist for the Institute.

Key participants for Wyandotte Chemicals are Lester Lundsted, Ph.D., director of inorganic and organic research and development, and John J. Ronayne, M.D., Medical director.

"We are delighted that our Research Institute will have the active support and cooperation of Wyandotte Chemicals Corporation in this encouraging line of research," commented Owen R. Pinkerman, vice president and director of William Beaumont Hospital.

"The project is unique in that it is based on a direct partnership between a basic manufacturing industry and a public service institution. We believe that a close association of the original manufacturer and the institutional user of key products can contribute greatly to better care of patients."

In the past year and a half Beaumont Hospital Research Institute scientists have published some 16 papers on the results of their special studies, have 11 additional papers in press, have filed several patent applications on procedures or equipment developed for their investigations, and have addressed a number of scientific conclaves in this country and abroad.

In order to support their efforts with more adequate facilities, Mr. Pinkerman said, plans have been made for a separate research building in the rapidly expanding Beaumont Hospital medical complex.

TB DEATHS, CASES INCREASE IN MICHIGAN

The number of reported TB cases in Michigan during 1966 increased over the two previous years. A total of 3,259 new cases were reported in 1966 with 2,263 recorded as active, according to the Michigan TB and Respiratory Disease Association.

In 1965 there were 289 reported TB deaths as compared to 301 in 1966. The increase was predicted as a result of increased TB control activities and Michigan and authorities feel that better case detection and new TB legislation will discover even more TB in the forthcoming year.

MDPAC Encourages Physicians, Others To Understand Issues

"To encourage physicians and others to understand the nature and actions of their government, as to important political issues, and as to the records of office holders and candidates for elective officers."

That is the second purpose listed in the constitution of the Michigan Doctors Political Action Committee.

There are many key words in that important MDPAC purpose. The word "encourage" certainly sets the climate for MDPAC work. "Encourage" is a strong action verb and workshops, letters, articles, and other communication efforts all seek "to encourage. . ."

MDPAC accepts memberships not only from doctors of medicine but from the "spouse and members of the immediate family and others," according to the constitution. The second purpose recognizes that physicians and "others" need to understand government and politics. MDPAC members should not hesitate to invite others to join the movement.

The second purpose of MDPAC calls for the members to be students of every day events. "Important political issues" should be understood. This can be done by reading newspaper articles, by following radio and television programs, by talking to political party leaders, by writing to congressmen for their views, etc.

Every physician, wife, and others are challenged in this purpose to know about the voting records of their senators and representative in Washington. MDPAC will maintain a scorecard of Congress voting on issues and will consider such performances when moving into support efforts.

MSMS members may obtain a copy of the complete MDPAC Constitution and a membership application by writing to MDPAC, Box 169, East Lansing.

—Vernon V. Bass, M.D., Chairman
MDPAC

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bisacodyl

Few drugs work as predictably as Dulcolax. You can expect that when your office patient takes Dulcolax at home, it will be as effective as you said it would be. Your patient will be gratified, too.

The reliability of Dulcolax stems from its unique mode of action. The drug works directly on nerve endings in the colonic mucosa, producing normal peristalsis throughout the large intestine. It does not rely on systemic absorption for its effect.

This reliable action provides prompt relief of constipation. It also makes Dulcolax particularly useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.

11
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predictable bowel evacuation

Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

General Dosage Information: *Adults:* When an ordinary laxative effect is desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets must be swallowed whole, not chewed or crushed, and should not be taken within one hour of antacids or milk. *Children:* 1 or 2 tablets, depending on age and severity of condition. Tablets must not be given to a child too young to swallow them whole. For infants and children under 2 years of age, half a suppository is usually effective. Above this age a whole suppository is usually advisable. Side Effects: As with any laxative, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

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Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.

"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning – May be habit forming),
Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

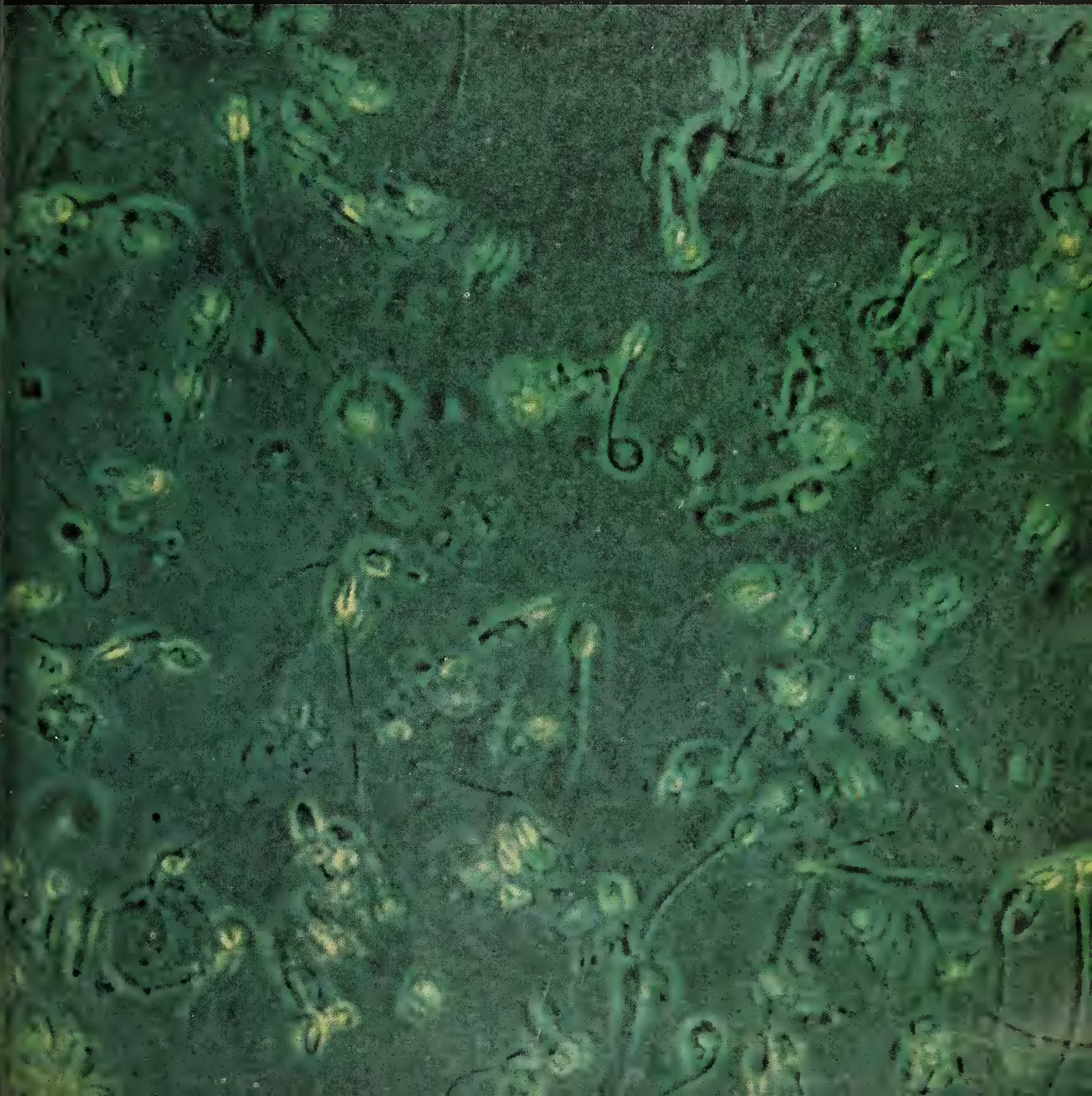
■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidenc in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast change (tenderness, enlargement and secretion), change in weight (increas or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestati jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, an itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic functio tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

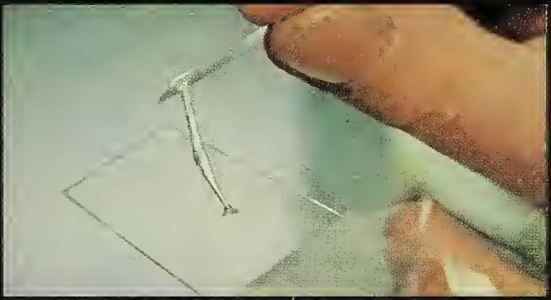
SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

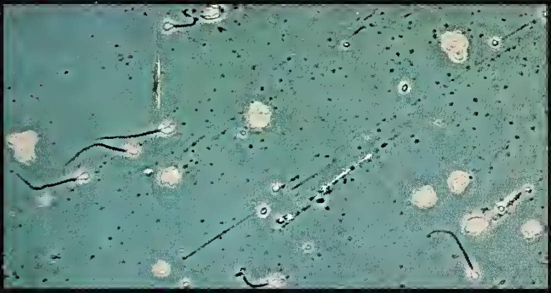
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

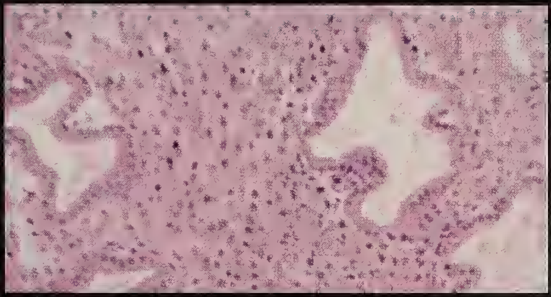
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

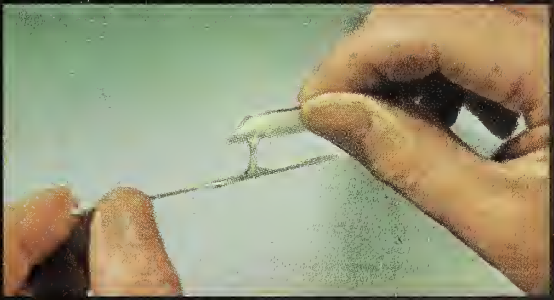


Spermatozoa appear healthy, active, freemoving.

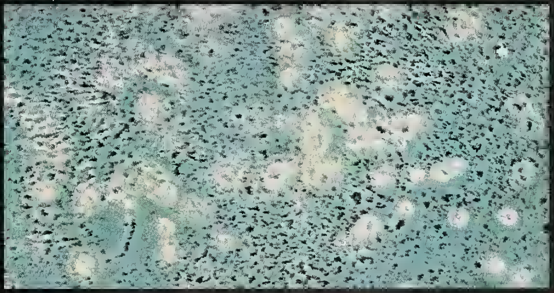


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

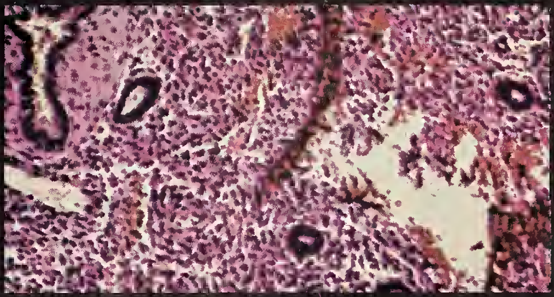
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg. c̄ mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
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- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®

fluocinolone acetonide

Turn page for contraindications, precautions and side effect

For everyday topical steroid therapy
Synalar® 0.01%
fluocinolone acetonide
provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide — an original steroid from
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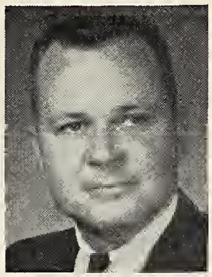
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Detroit, Michigan
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Jack Eggerding
E. Grand Rapids, Mich.
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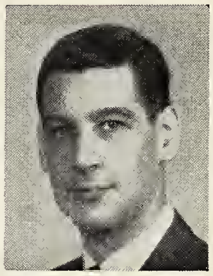
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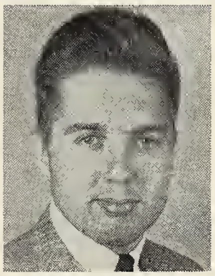
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Doctor Willard, vice president for the Medical Center at the University of Kentucky and chairman of the AMA Ad Hoc Committee, delivered this speech at the MSMS Annual Scientific Session on Wednesday, September 27, 1967.

The New Physician

BY WILLIAM R. WILLARD, M.D.
LEXINGTON, KENTUCKY

As background for this discussion entitled "The New Physician," you will recall that last year (1966) witnessed three significant reports germane to this topic: The Millis Commission report, *Graduate Medical Education;* the report of the National Commission on Community Health Services, *Health is a Community Affair;* and the report of the AMA Ad Hoc Committee on Preparation for Family Practice, *Meeting the Challenge of Family Practice.*

All three of these reports strongly emphasize the need for a "new" physician if modern health care is to be delivered to the people in a satisfactory way. The Millis Commission called this "new" practitioner the *primary physician;* the National Commission on Community Health Services called him a *personal physician;* and the Ad Hoc Committee used the term *family physician.* These are merely different terms for the same kind of physician. Perhaps the nomenclature complicates discussion unduly; let us hope it does not pose barriers to understanding.

ALL THESE REPORTS reflect the current dissatisfaction of the public with the delivery of modern health care. Public criticism is reflected by such problems as the difficulty in securing a physician when wanted, particularly at night and over weekends; by the increasing public use of hospital emergency rooms; by the many popular articles in newspapers and magazines; by studies of the American Academy of General Practice; and by recent Federal legislation which emphasizes primarily the delivery of health services rather than health education or research. The single greatest demand on the placement service of the AMA is for family physicians, a demand which is difficult to fill.

Dissatisfaction has been voiced by members of the medical profession in more sophisticated ways. The problems are described in these terms: Many people have difficulty in obtaining ready access to their community health care systems — if indeed they can be called systems.

Medical care is highly specialized, fragmented and often uncoordinated; it lacks continuity, and instead, is episodic in character. Often, it is impersonal and lacks emphasis upon disease prevention, health maintenance and rehabilitation. The social and environmental factors involved in illness receive inadequate attention as do the emotional problems and tensions which contribute so heavily to health problems. The physician often does not evaluate the patient's problems in the context of his family. In short, modern health care has been criticized as not being comprehensive, efficient, or economical.

Community Medicine Neglected

In addition, community medicine is neglected. The physician is charged with failing to appreciate the need for an organized attack upon community health problems — an attack which will develop the necessary, but lacking, resources for modern health care — and with failing to promote changes which will help overcome the economic and other barriers that make it difficult or impossible for some people to secure health care. As a result, physicians as a group are charged with being negative and opposed to progress. As rugged individualists, they are charged with being poor members of a eam and with providing inadequate leadership or the health team.

There is a more optimistic view of this picture than that which I have painted. Some studies report that members of the public are quite satisfied with their own physicians but are unhappy with the corporate stance of medicine as it attempts to deal with problems which require an organized attack for solution. Whether or not the picture I have painted is overdone, there is a growing conviction, in both lay and professional circles, which indicates a serious problem faces the medical profession.

IT IS IRONICAL that there seems to be an increase in public dissatisfaction when medicine can offer so much more now than it ever could before. We have more and better hospitals and other facilities; our physicians are better trained in scientific medicine than ever before; many disease and disability problems now respond to successful remedial care when only a few years ago medicine could offer nothing but symptomatic therapy for them.

The very success of modern medicine has created a growing demand for health services, a demand augmented by the ability of people to pay for such care through voluntary or governmental prepayment mechanisms. Perhaps this growing demand, which appears to outstrip our resources for delivering care, in large measure is behind the ironical fact that as we become more successful we create a growing criticism on the part of the public.

The Millis Commission considers the problems resulting in these criticisms as symptomatic of medicine's attempts to adapt to the era of specialization. Perhaps the most significant phenomenon in the evolution of medical practice is specialization, and this is destined to become even greater as research advances knowledge and creates an increasingly complex technology. Clearly, specialization and modern technology accompanied by social changes in our society have resulted in profound changes in the way medicine is practiced and health services are delivered to the people.

Nevertheless, how the coordination of specialty medicine and a comprehensive approach to the health problems of the patient as a whole man not just the problems of a diseased organ or organ system, can be handled effectively, poses one of the major challenges the medical profession faces. The public senses this problem, although it may not fully understand its complexity or know how to solve it satisfactorily.

Dr. Leo Simmons, a sociologist interested in the health field, has stated that it requires the same amount of time, energy, commitment, and resources to deal with the problem of coordinating specialty services as that required to develop new knowledge and skills which require specialization. Personally, I am convinced that he is right, and only now are we beginning to face this problem squarely, to explore how coordination can be achieved and how the resources for program implementation can be provided.

This problem is not unique to medicine; it is a general problem which faces society as it attempts to deal with increasing knowledge and technology in many fields in a highly interdependent society.

THE DEVELOPMENT OF A new physician, call him "family," "primary," or "personal" physician, is considered one essential component of an answer to this problem. At least that is the conclusion reached in the reports of The Millis Commission, the Commission on Community Health Services, and the AMA Ad Hoc Committee on Preparation for Family Practice. For the remainder of this paper I shall use the term "family physician" in the interests of semantic simplicity, and I would point out that the family physician, as conceived in these reports, is not a general practitioner by definition.

Family Physician Defined

The family physician may be defined as follows:

"The family physician is one who: 1) serves as the physician of first contact with the patient and provides a means of entry into the health care system; 2) evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care; 3) assumes responsibility for the patient's comprehensive and continuous health care and acts as leader or coordinator of the team that provides health services; and 4) accepts responsibility for the patient's total health care within the context of his environment, including the community and the family or comparable social unit."

THE BASIC DIFFERENCE between the family physician and the general practitioner is that the

THE AUTHOR
DR. WILLARD

"family" physician provides continuous, coordinated care for the patient within the context of his family setting; the general practitioner, by definition, does not necessarly provide such care. He may, and usually does, provide episodic care in more than one field of medicine. If he provides continuous comprehensive care in the context or the patient's family, then he can truly be considered a "family" physician.

Similarly, some of our traditional specialists also provide continuous and comprehensive care; to the extent that they do, they may also be considered "family" physicians. Although the concept of comprehensive care is not new and is, in fact, practiced by a number of physicians, it is practiced by too few to satisfy the needs of the public.

The report of the AMA Ad Hoc Committee on Preparation for Family Practice deals in greater detail than the other reports with the requirements for preparing such a physician. In contrast to previous studies on this subject (e.g., the Weiskotten Report of 1959), this report looks upon the whole educational process for practice as a continuum.

Programs of graduate medical education, upon which the focus was limited in previous reports, can be planned and conducted effectively only in the context of the total educational program for medicine. The medical school programs have changed so much in the last two decades that programs of graduate education should have changed in an adaptive way. Graduate education has changed, but not in coherent or efficient ways when viewed in the context of the total educational experience of the student. The present system, with its multiple, autonomous specialty boards, the participation of independent hospitals and medical schools, state licensing boards, and various accrediting agencies for hospitals and educational programs, is badly fragmented. It is called by some a disorganized, rather than an organized system, one that certainly is not effectively coordinated.

Undergraduate Program

The AMA Ad Hoc Committee recognized the key role of the "undergraduate" medical school program. It noted the need to select medical students who might have an interest and aptitude for family practice. It noted the influence of the medical school program upon career choices of the student and felt that medical schools generally are oriented and organized to emphasize the traditional specialties rather than family practice, that the programs do not usually offer the breadth and flexibility needed today. It particularly noted the absence of suitable models of comprehensive health care where students could see and participate in such a program, could learn some of the techniques and develop an interest in family practice.

THE COMMITTEE RECOGNIZED that medical schools need defined organizational units of full-time faculty competent in family practice to organize and demonstrate such models of practice and, that to achieve such models, a school needs a defined population group for which it takes responsibility of providing comprehensive, continuous care. The population group need not be large; it should be large enough to meet the needs of the teaching programs, but no larger. It should be representative of the population of the area; a group that is entirely indigent is not satisfactory.

As for the subject matter content, the program should draw upon the existing disciplines, particularly internal medicine, but also upon pediatrics, obstetrics and gynecology, psychiatry, and surgery. It should place particular emphasis upon community medicine and the behavioral sciences, upon preventive medicine; health maintenance; the frequent diseases, particularly the chronic ones; and upon emotional problems of patients.

To achieve what is necessary, the graduate program should not be solely a rotation of students among traditional specialties for various periods of time, although such rotations have a place in providing depths of knowledge and technical skills. Rather, in the model of practice, the program must provide experience for house staff as well as medical students, in comprehensive care for patients of a defined population group over a period of time.

The AMA Ad Hoc Committee visualized an intern-residency program no less demanding, although differently organized and oriented, than programs now provided for the traditional specialties. It did not visualize the preparation of a second class physician, but the preparation of a superior physician well qualified in scientific medicine whose training would emphasize breadth rather than depth in most specialty fields. The Committee recognized that the needs of a community and its demands upon a physician and the interests of students vary; programs, therefore, should provide flexibility to accommodate the special interests and goals of students and should recognize that some students can acquire, in addition to the broad and comprehensive approach, depth in particular fields of interest provided they obtain suitable training.

IN SHORT, THE PROGRAM visualized would prepare a skilled physician, well trained in modern scientific medicine, but with a philosophy and orientation suitable for the practice of comprehensive medicine.

The AMA Ad Hoc Committee realized there is more to the problem than just the education of

Continued on 1518

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the physician. The organization and environment of practice are also important. If the physician does not have the supporting facilities and services — the hospital, laboratory, necessary backup services, association with stimulating associates, and continuing education — he cannot practice modern medicine and will not be attracted to areas of practice in which these factors are absent. The Committee recognized as an essential pattern of the future the formal and informal association of physicians in groups.

THE COMMITTEE ALSO recognized that, if a physician were adequately trained as outlined, he could demand and would deserve appropriate status and recognition. In the Committee's view, this means that the properly trained family physician of the future deserves specialty recognition because his training, although different from that of other specialists, will be equally demanding and will require a level of skill and competence just as great.

The Committee realized that medical schools today do not have faculty, generally speaking, who are trained for, and interested in, family practice. Furthermore, there are few successful examples of family practice training programs. To develop faculty and programs will require time, much experimentation, and adequate financial support.

Filling the Vacuum

In discussing measures for filling the vacuum of family physicians, the Millis Commission stated: "It is time for decisive action to increase greatly the number of physicians who will devote their careers to the highly competent provision of comprehensive and continuing medical services (i.e., the family physician). If organized medicine does not take the leadership in meeting this problem, others will." The Millis Commission report further states: "It is time for a revolution, not a few patch work adaptations."

THESE ARE STRONG words but how has the profession reacted? Specifically, how has it reacted to the proposals of the Ad Hoc Committee on Family Practice? Many physicians have exhibited enthusiasm and expressed strong support. Other physicians and some medical educators have expressed skepticism. They see the recommendations as an attempt to stem the tide leading inevitably toward greater specialization. They doubt that this is possible or even desirable. They question whether the public really wants the family physician and will use him if they have access to specialists. Many of these physicians are politely skeptical and interested in seeing what will happen, but not personally concerned one way or another. There ar some, however, who view the recommendations c this report with hostility.

Views of Critics

The critics point out that virtually every physician functions as a first contact physician and tha many of them — internists, pediatricians, surgeon obstetricians and gynecologists and others — ofte function as the coordinator for patient care. Th internists and pediatricians in particular feel tha most of their members, in fact, now serve as family physicians.

The AMA Ad Hoc Committee does not questio the fact that virtually all physicians serve as firs contact physicians and that a number of them particularly the internists and pediatricians, serv as coordinators of patient care and function successfully as family physicians. The Ad Hoc Committee believes, however, that, generally speaking they have not been trained for this role and, as result, do not perform it as well or satisfactoril as they might. Those who practice this kind o medicine do so because of their own attitudes, philosophy, and interests; they practice this type o medicine not because of, but in spite of, their preparation. If this is a valid conclusion, and I think i is, then the preparation of many physicians fo this type of practice will result, perhaps, not in a "new" physician but in many more physicians o a kind urgently needed. The Committee acknowledges that some of the training programs, particularly in medicine and pediatrics, would not require major changes in order to provide satisfactory preparation for family practice.

The internists and pediatricians in particular are not convinced that family practice is truly a specialty and warrants specialty recognition. They believe family practice reflects, not a new and discreet body of knowledge worthy of specialty recognition, but more an attitude and philosophy, a mode of practice. They doubt whether the mere creation of a specialty board with specialty recognition will contribute much to the solution of the problem. However, they are not opposing efforts toward a specialty board recognizing family practice (efforts which are now underway), but they are watching these efforts critically to see whether or not they will result in programs exemplifying high standards of quality. They believe these programs should develop first and specialty recognition follow, whereas the advocates of specialty recognition believe that the programs are not likely to develop because there will be too few "takers" unless there is specialty recognition for those who will undertake training in the new program.

Which Comes First?

It seems to be the question of which comes first, the chicken or the egg; the fact that in other specialties training programs were created first does not mean necessarily that, in this day and age, this sequence of events can be followed.

In some respects, the current emphasis upon specialty board recognition is unfortunate because it is only part of the problem visualized by the Ad Hoc Committee and, at the moment, is receiving, perhaps, undue emphasis for a balanced attack on the problem.

Perhaps it will be helpful, in putting this issue in perspective, to quote from an article by McWhinney of Great Britain entitled "General Practice as an Academic Discipline — Reflection after Visit to the United States." (McWhinney uses the term "general practice" to mean family practice as defined by the Ad Hoc Committee).

"It is not necessary to define this (body of knowledge for family practice) very strictly. In some disciplines, the limit must always be vague. Who, for example, can define exactly the limits of internal medicine or general surgery? Moreover, as a discipline grows and new challenges arise, the field of knowledge changes and each new generation has to master new concepts."

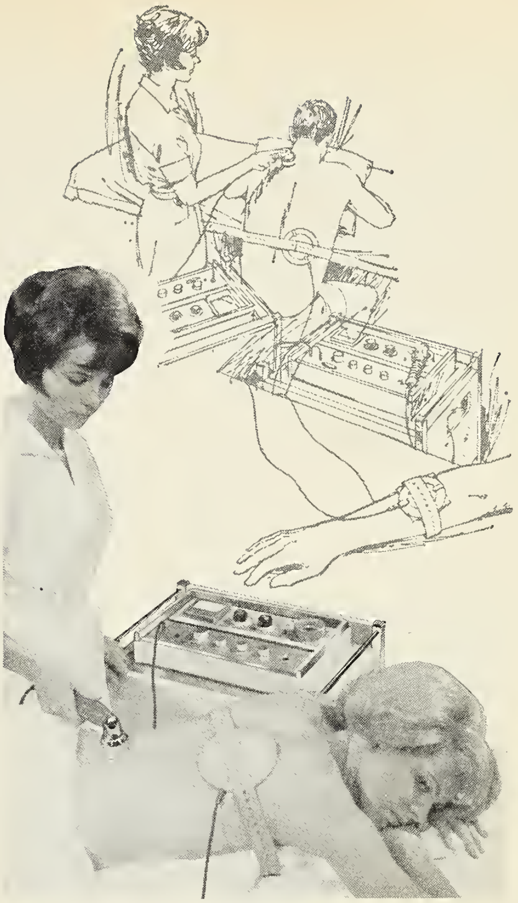
"MOST DISCIPLINES in medicine are derived from a number of others. Surgery, for example, draws knowledge from anatomy, pathology, physiology, and biochemistry. In defining a discipline, however, it is not enough to list all the subjects in which it has its roots. These parent disciplines must be melted down, amalgamated and molded into a new form vitally different from each of its ingredients. It is not sufficient, therefore, to say that general practice consists of internal medicine, pediatrics, psychiatry, and social medicine; the knowledge required by general practitioners is different both in degree and kind from that needed by the specialist in any of these subjects."

"Much time has been wasted on sterile arguments about whether or not general practice is a specialty. Specialization is always a matter of degree. . . ."

In the long run, however, there must be a better definition than we have now of this amalgam of new knowledge and how it differs from other fields, both in degree and kind. The Millis Commission report admits that "it is difficult for this body of knowledge for it is not yet adequately developed." How can one examine for a new body of knowledge, or even a unique composite of knowledge, unless it can be well defined? Truly, this is one of the important dilemmas facing the advocates of the "new" physician.

Family Practice Is A Specialty

Acknowledging this handicap, the Ad Hoc Committee considers that family practice is a specialty, not only because it believes there is a new and composite body of knowledge significantly different



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from that used by other specialists being developed, but also because the function of the family physician is different from that of other specialists. The Committee believes it is time to redefine a specialist and that it is just as valid, perhaps more valid, to use the physician's functional role in health care as it is to use a particular body of knowledge, skills, techniques, organ systems or age groups of the patients as the basis of a specialty.

WELL, ONE MAY ASK, where do we go from here? It is clear that the three reports mentioned have provoked much discussion, much introspection by the profession, and much debate about the shape of things to come and the directions in which we should move. Whatever your fields of medicine and whatever may be your biases, I would urge you not to dismiss lightly the conclusions of the three reports I have mentioned. I invite you to participate in the emerging dialogue, to be as critical as you wish about any of the ideas, proposals or philosophies advanced, but critical on the basis of having read the reports accurately and on the basis of expressing facts, whenever possible, rather than just opinions and biases.

More specifically, I urge you to support experimental efforts for the development of the programs for family practice. After all, the issue will be settled by experimentation and performance rather than by philosophical arguments. I would point out specifically the recommendation of the Ad Hoc Committee which deals with models of practice in medical school programs as well as in community hospitals with family practice intern-residency programs. The models of practice require the access to, and control of, defined population groups by the teaching institution. This requirement should not be viewed with alarm as that of a medical school trying to compete unnecessarily or unfairly with private practice.

Only a small segment of the population will be required, but it is an essential requirement for proper training programs of the future. I would urge you also to support research conducted by medical schools and particularly research by family practice units as they develop, in an attempt to find new patterns of more efficient patient care. Such meager efforts as we have had in this direction in the past have often been interpreted by the practicing profession as an attack upon the hallowed institution of private practice. Private practice is changing, and it is important that we find patterns for the future that will meet social needs and demands and, at the same time, will maximize the independence of the profession. We need new patterns that will retain the incentives and values of our private enterprise system. If we cannot look at new ways of doing things in a friendly, cooperative and constructive manner, then new ways will be developed in which we have no voice and no role.

We should consider the medical schools which conduct such research and demonstration programs as partners looking for better ways to practice medicine, not as institutions desiring to compete and to destroy the essential values for private practice. In time, the medical school facilities should be able to look to the medical profession as friendly, constructive critics, not as enemies.

And In Closing

Finally, I would urge you not to be "oversold." No rational person believes that the preparation of the "new" physician as I have described it will solve all the problems facing either medical education or medical practice. It is only one of many important issues before the profession, but it is an important one. Before success can be achieved, there is a long row ahead of trial and error, of experimentation, of marshalling the necessary financial and other resources to do the job. I hope that you will be helpful rather than obstructive in this effort.

If successful, we will have developed a more effective role for medicine in meeting the health needs and desires of the public. We will have created a "new" physician who will have a high and respected status among his colleagues, one who will help create a new public image for medicine — one which will redound to our credit and advantage.

Thirteen Michigan community colleges are training practical nurses to help meet the health manpower needs. And others are being trained in hospital-based programs. Grand Rapids Junior College Instructor Miss Patricia Colvin, second from left, demonstrates blood pressure techniques to Miss Marilyn Hart, left, Miss Ellyn Spaanstra, third from left, and Mrs. Margaret Spalink, far right.

SAYS NURSES NEED CONTINUING EDUCATION

Continuing education can help to meet the nation's nursing needs, Michigan's operating room nurses and supervisors were told at a recent Michigan State University conference.

Miss Frances Ginsberg, consultant with the Bingham Associates Fund, Tufts-New England Medical Center, Boston, said "nurses must be placed within an economic security range which enables them to make their contribution to society and still participate in community life and social activities."

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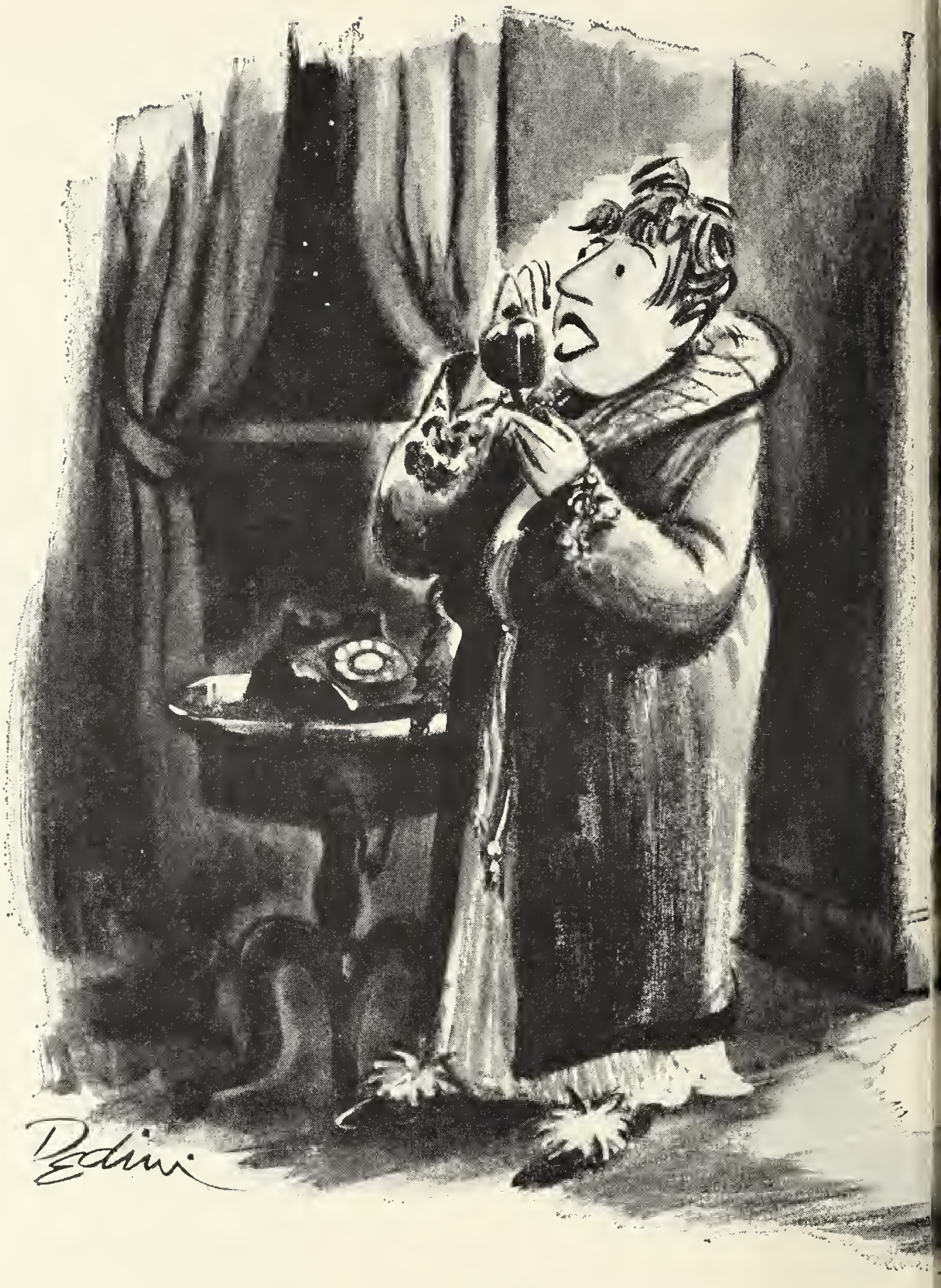

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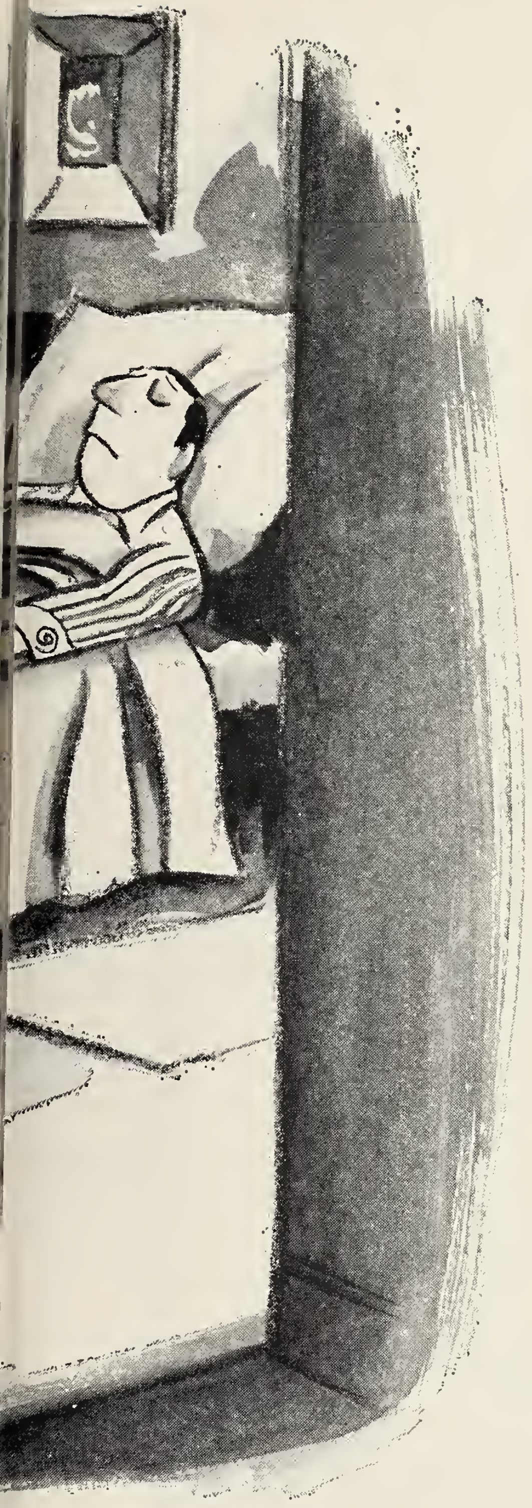

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Robert C. Johnson, M.D., 116 Cass Street, Traverse City, 49684.
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John R. Pfeifer, M.D., 15901 West Nine Mile Road # 600, Southfield 48075.
Iraj Rafani, M.D., 3219 Belle Court, Royal Oak 48072.
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Kenneth W. Teich, M.D., 900 Woodward Avenue, Pontiac 48053.

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HEART-CANCER-STROKE GRANTS CONTINUING

The National Institutes of Health report that the following statistics to date on the Heart-Cancer-Stroke programming under Public Law 89-239:

Grants to assist planning have now been made to 49 regions and applications for at least five other anticipated regions are under review or development; the awards for the first year of planning have amounted to about $20 million; in addition to these planning grants, awards for operational programs have now been made to five regions.

The coordinated headquarters of these regions are located in Albany, New York; Columbia, Missouri; Kansas City, Kansas; Salt Lake City, Utah; and Milwaukee, Wisconsin.

The Michigan Association of Regional Medical Plans received a grant in June of $1,285,155 to finance a headquarters operation and to begin planning proposals presented by the three Michigan medical schools and the Michigan Department of Public Health.

MSU APPOINTS TEXAN CHAIRMAN OF ANATOMY

Bruce E. Walker, M.D., Ph.D., former associate professor of anatomy at the University of Texas Medical Branch, Galveston, is the new chairman of the Department of Anatomy at Michigan State University. He succeeds M. Lois Calhoun, D.V.M., Ph.D., chairman for the past 19 years. Doctor Calhoun is resigning as chairman to devote more time to research, teaching, and writing.

A graduate of McGill, he has authored nearly 70 technical articles dealing with such varied research areas as: studies on the development of normal and cleft palate in laboratory animals; the effects of muscular dystrophy and other trauma on the regeneration of muscular tissue; effects of trauma on the brain, and respective roles of the nucleus and cytoplasm in the differentiation of cells.

GOVERNOR NAMES SABIN TO NORTHERN BOARD

Governor Romney announced the appointment of Fred C. Sabin, M.D., Marquette, to the Northern Michigan University Board of Control.

Doctor Sabin is a former member of the State Board of Registration in Medicine.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

For complete details, please see full prescribing information.

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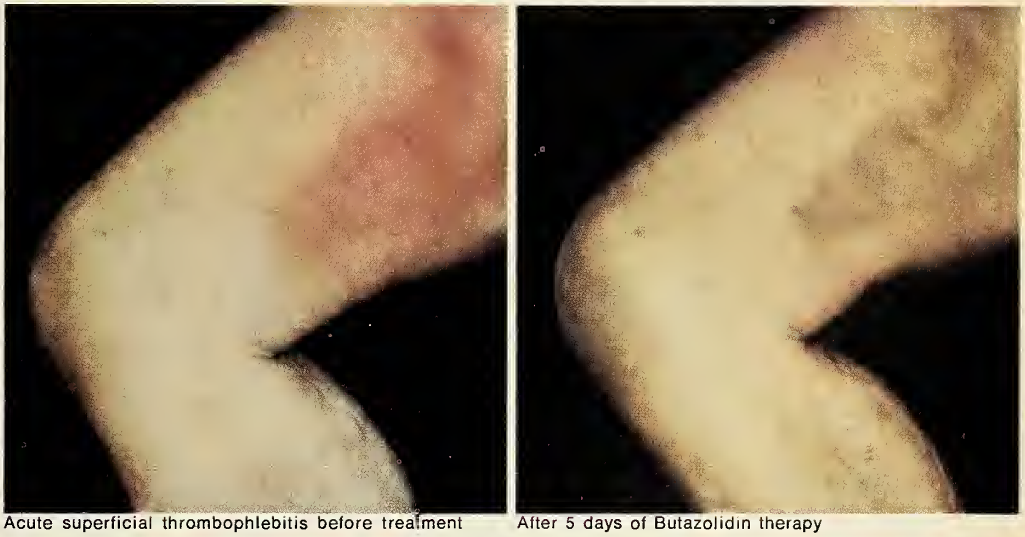

Acute superficial thrombophlebitis before treatment
After 5 days of Butazolidin therapy

In acute superficial thrombophlebitis, patients were usually bedfast for 2 to 4 weeks, tying up hospital beds, requiring costly nursing care and time-consuming procedures such as warm soaks and packs.

When Butazolidin was added to the usual regimen, 960 of 1000 patients obtained complete resolution; most required only 30 capsules or tablets; relief of pain and discomfort and regression of inflammatory signs and fever occurred within a few days.*

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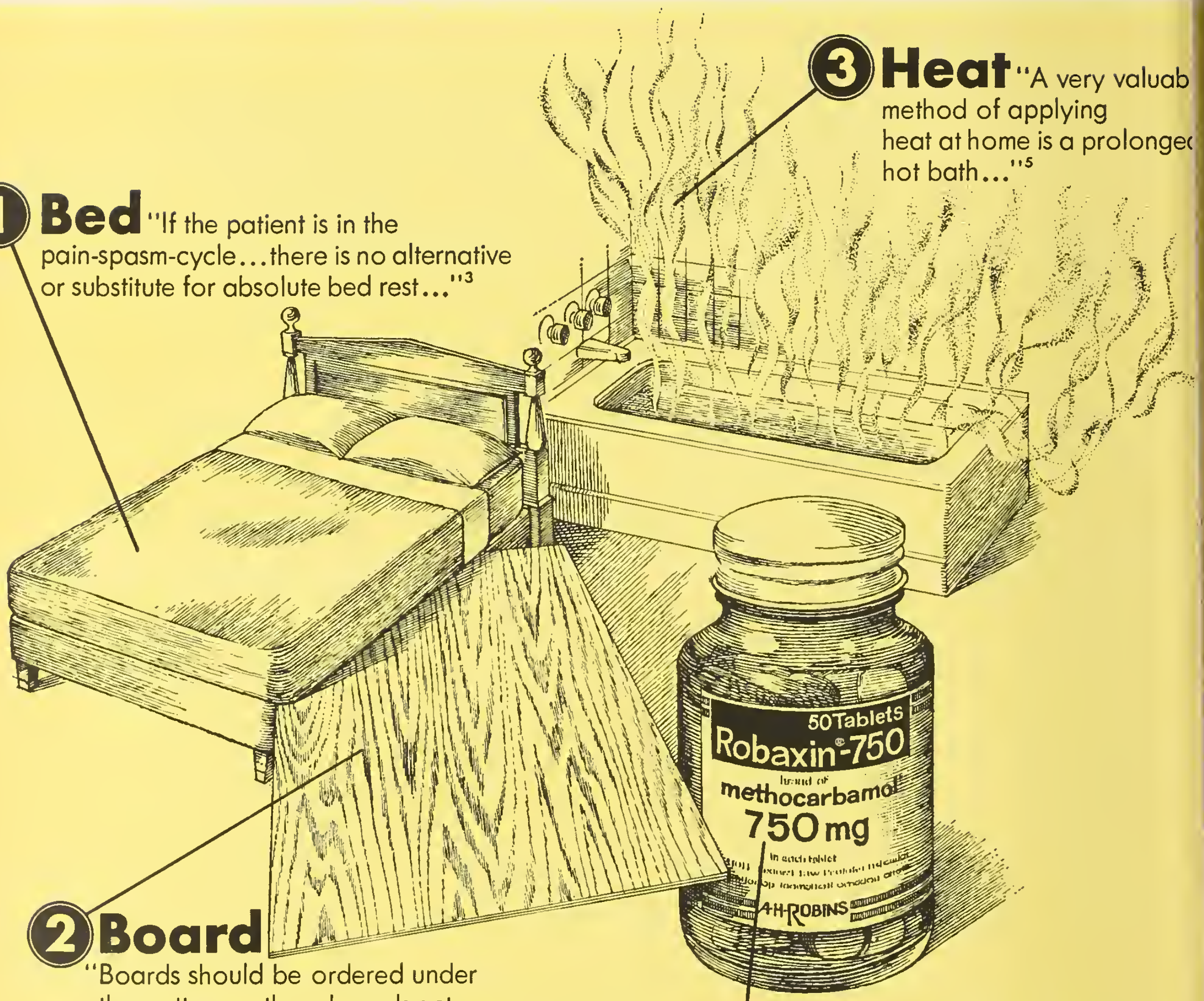

① Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

② Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

③ Heat "A very valuab method of applying heat at home is a prolonge hot bath..."[5]

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Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.) **References:** (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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in memoriam

FERDINAND COX, M.D.

Ferdinand Cox, M.D., past president of the ackson County Medical Society, died August 22. He was 86.

Doctor Cox received his premedical education t Ferris Institute and was graduated from the University of Michigan Medical School in 1909. A native of Liberty Township, he had practiced n Horton, Michigan, and Oakland, Illinois, before he moved to Jackson in April 1918.

A Life Member of the Michigan State Medical Society, Doctor Cox belonged to the general prac-ice association and to the Masonic Lodge, of which he was a Life Member. He was affiliated with W. A. Foote Memorial Hospital in Jackson.

For many years Doctor Cox served on the State Selective Service Appeal Board at Lansing and also as local medical examiner for the Board.

NATHANIEL GATES, M.D.

Nathaniel Gates, M.D., 85-year-old Detroit general physician, died August 30. He had practiced in Detroit for nearly fifty years.

Doctor Gates received his B.S. degree from the City College of Philadelphia and his M.D. degree from the University of Pennsylvania Medical School in 1905. The University of Pennsylvania in recent years gave him its Distinguished Service Award.

He had served as senior attending surgeon at Woman's Hospital in Detroit and at Einstein Memorial Center and Mount Sinai Hospital in Philadelphia. He had been associate attending surgeon at Philadelphia Polyclinic Hospital and instructor of anatomy and operative surgery at the University of Pennsylvania Medical School from 1906 to 1918. In Philadelphia, Doctor Gates was a member of the College of Physicians, the Academy of Surgery, the Pediatric Society, and the Pathological Society.

In Michigan he belonged to the Detroit Academy of Surgery, and he was a Life Member of the Michigan State Medical Society. His medical fraternity was Sigma Xi.

D. M. MacGREGOR, M.D.

Delbert M. MacGregor, M.D., Flint internist, died September 7. He was 59.

A graduate of Alma College with an A.B. degree, Doctor MacGregor received his M.D. degree from the University of Michigan Medical School in 1934. He practiced in Flint from 1935 until his retirement in 1966.

Doctor MacGregor was a member of the Academy of General Practice and Nu Sigma Nu and Tau Kappa Epsilon medical fraternities.

He was affiliated with Hurley, St. Joseph, and McLaren General hospitals in Flint.

A. C. RUTZEN, M.D.

Arthur C. Rutzen, M.D., Detroit obstetrician and gynecologist, died September 5 at the age of 54.

Born at Menominee, Doctor Rutzen was graduated from Wayne State University Medical School in 1940. He was associate clinical professor of obstetrics and gynecology at Wayne and was director of the DIMC clinic at Crittenton Hospital, where he was a former chief of obstetrics. He was affiliated also with Herman Kiefer Hospital in Detroit.

A past chairman of the MSMS Committee on Maternal Welfare, Doctor Rutzen had also served as chairman of the Resident Education Committee of the Michigan Society of Obstetrics and Gynecology. He was a fellow of the American College of Obstetrics and Gynecology and was a member of Phi Beta Pi medical fraternity.

H. O. STALEY, M.D.

Hugh O. Staley, M.D., Omer, Director of the Tawas Area Medical Facility, was hit and fatally injured by an automobile on August 21. He was 61.

Born at Burl Retreat, Virginia, Doctor Staley received his education at William and Mary College and the University of Virginia School of Medicine. After completing his residency in surgery at Charleston, West Virginia, Doctor Staley moved to Omer where he purchased Omer and Standish hospitals. He ran the two units in conjunction until 1962, when he sold them to Standish Community Hospital Association.

Doctor Staley was a fellow of the American College of Surgeons.

WSU, COUNTY RECEIVE GRANT FROM PRESCAD

A $707,422 grant for Project PRESCAD, a comprehensive medical care program for indigent children in the Wayne County area, has been made to Wayne State University and the Wayne County Department of Health. Morton Levitt, Ph.D., Detroit, associate dean of WSU's School of Medicine, is supervising the program. The PRESCAD program constitutes one of three contracts made with the Wayne health department.

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MICHIGAN STATE MEDICAL SOCIETY DIRECTORY

Members of the Michigan State Medical Society will find this 1967-68 issue of the Directory very useful. In addition to the several listings of the MSMS members, the Directory includes valuable reference information about the Michigan State Medical Society and its committees, the American Medical Association, etc.

The Publication Committee of The Council welcomes your suggestions.

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MICHIGAN STATE MEDICAL SOCIETY DIRECTORY

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This Directory lists the membership of each component medical society and therefore the total membership of the Michigan State Medical Society. For more effective reference use, the directory also contains an alphabetical list of all MSMS members, with a reference to both the page number and the county society code number.

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Alpena County (Alpena-Alcona-Presque Isle)	14	19
Antrim (Northern Michigan)	170	44
Arenac (Bay-Arenac-Iosco)	22	20
Baraga County (Houghton-Baraga-Keweenaw)	82	27
Barry County	18	19
Bay County (Bay-Arenac-Iosco)	22	20
Benzie County (Grand Traverse-Leelanau-Benzie)	70	26
Berrien County	26	20
Branch County	30	21
Calhoun County	34	21
Cass County	38	22
Charlevoix County (Northern Michigan)	170	44
Cheboygan County (Northern Michigan)	170	44
Chippewa County (Chippewa-Mackinac)	42	23
Clare County (Gratiot-Isabella-Clare)	74	27
Clinton County	46	23
Crawford (North Central Counties)	150	41
Delta County (Delta-Schoolcraft)	50	23
Dickinson County (Dickinson-Iron)	54	23
Eaton County	58	23
Emmet County (Northern Michigan)	170	44
Genesee County	62	24
Gladwin (North Central Counties)	150	41
Gogebic County	66	26
Grand Traverse County (Grand Traverse-Leelanau-Benzie)	70	26
Gratiot County (Gratiot-Isabella-Clare)	74	27
Hillsdale County	78	27
Houghton County (Houghton-Baraga-Keweenaw)	82	27
Huron County	86	27
Ingham County	90	28
Ionia County (Ionia-Montcalm)	94	30
Iosco County (Bay-Arenac-Iosco)	22	20
Iron County (Dickinson-Iron)	54	23
Isabella County (Gratiot-Isabella-Clare)	74	27
Jackson County	98	30
Kalamazoo County (Kalamazoo Academy of Medicine)	102	31
Kalkaska (North Central Counties)	150	41
Kent County	106	33

	County Code	Pag
Keweenaw County (Houghton-Baraga-Keweenaw)	82	2
Lake County (Mecosta-Osceola-Lake)	142	4
Lapeer County	110	3
Leelanau County (Grand Traverse-Leelanau-Benzie)	70	2
Lenawee County	114	3
Livingston County	118	3
Luce County	122	3
Mackinac County (Chippewa-Mackinac)	42	2
Macomb County	126	3
Manistee County	130	4
Marquette County (Marquette-Alger)	134	4
Mason County	138	4
Mecosta County (Mecosta-Osceola-Lake)	142	4
Medical Society of North Central Counties	150	4
Menominee County	146	4
Midland County	154	4
Missaukee County (Wexford-Missaukee)	226	5
Monroe County	158	4
Montcalm County (Ionia-Montcalm)	94	3
Montmorency (North Central Counties)	150	4
Muskegon County	162	4
Newaygo County	166	4
Northern Michigan Counties (Antrim-Charlevoix-Cheboygan-Emmet)	170	4
Oakland County	174	4
Oceana County	178	4
Ogemaw (North Central Counties)	150	4
Ontonagon County	182	4
Osceola County (Mecosta-Osceola-Lake)	142	4
Oscoda (North Central Counties)	150	4
Otsego (North Central Counties)	150	4
Ottawa County	186	4
Presque Isle County (Alpena-Alcona-Presque Isle)	14	1
Roscommon (North Central Counties)	150	4
Saginaw County	190	5
St. Clair County	194	5
St. Joseph County	198	5
Sanilac County	202	5
Schoolcraft County (Delta-Schoolcraft)	50	2
Shiawassee County	206	5
Tuscola County	210	5
Van Buren County	214	5
Washtenaw County	218	5
Wayne County	222	5
Wexford County (Wexford-Missaukee)	226	5
MSMS Membership Alphebetical List		7

Guide to Help Locate Cities within the Counties

This guide matches up the counties for all Michigan communities of 1,000 population or more.*

CITY and COUNTY

Adrian (Lenawee)
Albion (Calhoun)
Algonac (St. Clair)
Allegan (Allegan)
Alma (Gratiot)
Almont (Lapeer)
Alpena (Alpena)
Ann Arbor (Washtenaw)

Bad Axe (Huron)
Bangor (Van Buren)
Battle Creek (Calhoun)
Bay City (Bay)
Belding (Ionia)
Belleville (Wayne)
Bellevue (Eaton)
Benton Harbor (Berrien)
Berkley (Oakland)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Big Rapids (Mecosta)
Birmingham (Oakland)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Boyne City (Charlevoix)
Brighton (Livingston)
Bronson (Branch)
Brookline (Jackson)
Buchanan (Berrien)

Cadillac (Wexford)
Calumet (Houghton)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Carson City (Montcalm)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Center Line (Macomb)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)

CITY and COUNTY

Clawson (Oakland)
Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Coloma (Berrien)
Colon (St. Joseph)
Constantine (St. Joseph)
Coopersville (Kent)
Corunna (Shiawassee)
Croswell (Sanilac)

Davison (Genesee)
Dearborn (Wayne)
Decatur (Van Buren)
Detroit (Wayne)
Dexter (Washtenaw)
Dowagiac (Cass)
Dundee (Monroe)
Durand (Shiawassee)

East Ann Arbor (Washtenaw)
East Detroit (Macomb)
East Grand Rapids (Kent)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

Farmington (Oakland)
Fenton (Genesee)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Flushing (Genesee)
Fowlerville (Livingston)
Frankenmuth (Saginaw)
Frankfort (Benzie)
Fraser (Macomb)
Fremont (Newaygo)

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)
Gladwin (Gladwin)

CITY and COUNTY

Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Rapids (Kent)
Grandville (Kent)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Pointe (Wayne)
Grosse Pointe Farms (Wayne)
Grosse Pointe Park (Wayne)
Grosse Pointe Shores
(Wayne & Macomb)
Grosse Pointe Woods
(Wayne & Macomb)

Hamtramck (Wayne)
Hancock (Houghton)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Hart (Oceana)
Hartford (Van Buren)
Hastings (Barry)
Hazel Park (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Homer (Calhoun)
Houghton (Houghton)
Howell (Livingston)
Hubbell (Houghton)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

Imlay City (Lapeer)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

Jackson (Jackson)
Jonesville (Hillsdale)

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Kingsford (Dickinson)

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*See page 2 for Index by counties.

Guide to Help Locate Cities within the Counties/Continued

CITY and COUNTY

Lake Linden (Houghton)
Lake Odessa (Ionia)
Lake Orion (Oakland)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
Laurium (Houghton)
Lawton (Van Buren)
Leslie (Ingham)
Lincoln Park (Wayne)
Livonia (Wayne)
Ludington (Mason)

Mancelona (Antrim)
Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manton (Wexford)
Marcellus (Cass)
Marine City (St. Clair)
Marlette (Sanilac)
Marquette (Marquette)
Marshall (Calhoun)
Marysville (St. Clair)
Mason (Ingham)
Melvindale (Wayne)
Menominee (Menominee)
Michigan Center (Jackson)
Middleville (Barry)
Midland (Midland)
Milan (Monroe & Washtenaw)
Milford (Oakland)
Millington (Tuscola)
Monroe (Monroe)
Montague (Muskegon)
Morenci (Lenawee)
Mount Clemens (Macomb)
Mount Morris (Genesee)
Mount Pleasant (Isabella)
Munising (Alger)
Muskegon (Muskegon)
Muskegon Heights (Muskegon)

Nashville (Barry)
Negaunee (Marquette)
Newaygo (Newaygo)
New Baltimore
  (Macomb & St. Clair)
Newberry (Luce)
New Buffalo (Berrien)
Niles (Berrien)
North Muskegon (Muskegon)

CITY and COUNTY

Northville (Wayne & Oakland)
Norway (Dickinson)

Oak Park (Oakland)
Onaway (Presque Isle)
Ontonagon (Ontonagon)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
Oxford (Oakland)

Painesdale (Houghton)
Parchment (Kalamazoo)
Paw Paw (Van Buren)
Pentwater (Oceana)
Perry (Shiawassee)
Petersburg (Monroe)
Petoskey (Emmet)
Pigeon (Huron)
Pinconning (Bay)
Plainwell (Allegan)
Pleasant Ridge (Oakland)
Plymouth (Wayne)
Pontiac (Oakland)
Port Huron (St. Clair)
Portland (Ionia)

Quincy (Branch)

Reading (Hillsdale)
Reed City (Osceola)
Richmond (Macomb)
River Rouge (Wayne)
Riverview (Wayne)
Rochester (Oakland)
Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Roseville (Macomb)
Royal Oak (Oakland)

Saginaw (Saginaw)
Saint Clair (St. Clair)
Saint Clair Shores (Macomb)
Saint Ignace (Mackinac)
Saint Johns (Clinton)
Saint Joseph (Berrien)
Saint Louis (Gratiot)
Saline (Washtenaw)

CITY and COUNTY

Sandusky (Sanilac)
Saugatuck (Allegan)
Sault Sainte Marie (Chippewa)
Schoolcraft (Kalamazoo)
Scottville (Mason)
Sebewaing (Huron)
Shelby (Oceana)
Southfield (Wayne)
South Haven (Van Buren)
South Lyon (Oakland)
Sparta (Kent)
Spring Lake (Ottawa)
Stambaugh (Iron)
Standish (Arenac)
Stanton (Montcalm)
Stockbridge (Ingham)
Sturgis (St. Joseph)
Sylvan Lake (Oakland)

Tawas City (Iosco)
Tecumseh (Lenawee)
Three Rivers (St. Joseph)
Traverse City (Grand Traverse)
Trenton (Wayne)

Union City (Branch & Calhoun)
Utica (Macomb)

Vandercook Lake (Jackson)
Van Dyke (Macomb)
Vassar (Tuscola)
Vicksburg (Kalamazoo)

Wakefield (Gogebic)
Walled Lake (Oakland)
Warren (Macomb)
Watervliet (Berrien)
Wayland (Allegan)
Wayne (Wayne)
West Branch (Ogemaw)
Whitehall (Muskegon)
White Pigeon (St. Joseph)
Wyandotte (Wayne)
Wyoming (Kent)

Yale (St. Clair)
Ypsilanti (Washtenaw)

Zeeland (Ottawa)

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1971—GRAND RAPIDS, OCTOBER 3-8

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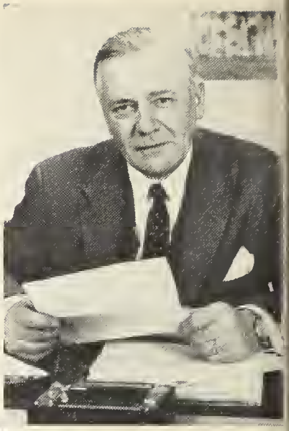

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Established 1924

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Certified for: Medicare and M.A.A. programs

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James R. Driver, M.D.
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Jacob J. Miller, M.D.
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Stephen C. Mason, M.D.
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* 1904 - 1967

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Mrs. Dorothy Brandis, Ingham Medical Hospital, Lansing

Handy List of Some Often-Used Addresses:

Michigan State Medical Society
    Headquarters: 120 West Saginaw, East Lansing 48823
    Detroit Office: 1010 Antietam, Detroit 48207
American Medical Association
    Headquarters: 535 N. Dearborn, Chicago 60610
    Washington Office: 1 Farragut Square, South, Washington, D.C. 20006
Michigan Association of Regional Medical Plans, 1111 Michigan, East Lansing
    Albert E. Heustis, M.D., Executive Director
Michigan Council on Smoking and Health, 712 Abbott, East Lansing
    Ben Yep, Coordinator
Michigan Doctors Political Action Committee
    P.O. Box 169, East Lansing 48823
Michigan Foundation for Medical and Health Education
    120 West Saginaw, East Lansing 48823
Michigan Health Council, 712 Abbott Rd., East Lansing
    John A. Doherty, Executive Director
Michigan Hospital Service (Blue Cross), 441 E. Jefferson, Detroit 48226
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    Board of Basic Science, 1033 S. Washington Ave., Lansing
        Diane Stanislaw, Admin. Sec'y
    Board of Registration in Medicine, 1033 S. Washington Ave., Lansing
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    Department of Public Health, 3500 N. Logan, Lansing
        R. G. Rice, M.D., Acting Director
    Department of Social Service, Lewis Cass Bldg.
        R. Bernard Houston, Director

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street
Chicago, Illinois 60610
(312) 527-1500
(TWX-910-221-0300)
(ANS BK-AMA CGO)

1 Farragut Square, South
Washington, D.C. 20006
(202) 783-8155
(TWX-710-822-9409)
(ANS BK-AMA DC)

AMA Officers:

President: Milford O. Rouse, M.D., Med. Arts Bldg., 1719 Pacific Ave., Dallas, Texas 75201, phone (214) RI 2-6143

President-Elect: Dwight L. Wilbur, M.D., 655 Sutter St., San Francisco, California 94102

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- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

Directory, Listed by Component Medical Societies

Special Memberships are indicated as follows: "L" for Life Members; "M" for Military Members; "N" for Non-Resident Members; "R" for Retired Members; "A" for Associate Members; all others are Active Members (Numbers in parentheses indicate County Society Code Numbers used in Alphabetical Roster.)

ALLEGAN COUNTY MEDICAL SOCIETY (10)

achman, A. Peter, Jr.. .222 Trowbridge St., Allegan 49010
own, Lewis F..........133 E. Allegan St., Otsego 49078
ase, Walter E.........137½ N. Main St., Plainwell 49080
lark, James I.....................Box B, Fenville 49408
erett, D. W........Plainwell Sanitarium, Plainwell 49080
oddard, G. B...............218 E. Orleans, Otsego 49078
oude, Albert G. (A)
ays, James D...........................Douglas 49406
hnson, Elwin B............412 Water St., Allegan 49010
hnson, Harrison H. (L)................Wayland 49348
eler, Van O. ....304 Dix St., Otsego 49078
ahan, James E.......402 Trowbridge St., Allegan 49010
edill, Wilbur C. (R)...139 N. Main St., Plainwell 49080
iller, Kenneth C.......................Saugatuck 49453
ogenhoef, Richard...........304 Dix St., Otsego 49078
Pone, Janis..............................Martin 49070
Ramseyer, Gladwin E......125 E. Bridge, Plainwell 49080
Schneiter, Harry E..........425 Cutler St., Allegan 49010
Schock, William H........315 Maple St., Saugatuck 49453
Smith, Ray C., Jr..........................Allegan 49010
Southern, Edward..........................Allegan 49010
Topp, E. Robert...........500 Allegan St., Plainwell 49080
Topp, Elwin W............353 Naomi St., Plainwell 49080
Van Der Kolk, Bert.......................Hopkins 49328
Vander Voord, Gerald....312 E. Plum St., Wayland 49348
Vaughan, Willard R. (L)................Plainwell 49080
Veenschoten, Girard (A).........Route 3, Cadillac 49601
Wheat, James..............................Allegan 49010
Wiseman, Bertha A...............Box 177, Allegan 49010

ALPENA-ALCONA-PRESQUE ISLE COUNTY MEDICAL SOCIETY (14)

liferis, Peter.........Alpena General Hosp., Alpena 49707
rscott, Edward F.....................Rogers City 49779
rown, Donald C......312 E. Chisholm St., Alpena 49707
unting, John W..........110 N. 1st Ave., Alpena 49707
urkholder, H. J. (L)..122 N. Second Ave., Alpena 49707
ohn, Stuart L.......1253 W. Washington, Alpena 49707
onstantine, Aeneas......................Harrisville 48740
nch, Donald E..........................Onaway 49765
ley, Richard.........................Rogers City 49779
x, William L.......601 W. Chisholm St., Alpena 49707
rause, Thomas J.....312 E. Chisholm St., Alpena 49707
reenwood, James.........115 N. First St., Alpena 49707
ier, Edward A.......125 N. Second Ave., Alpena 49707
ckson, Wm. F................RFD 1, Huron Shore Dr.,
Rogers City 49779
utsche, W. F................208 Lake St., Oscoda 48753
eopard, J. M............312 E. Chisholm, Alpena 49707
Lipski, John G. (A)..............Traverse State Hosp.,
Traverse City 49684
Nesbitt, Wm. E...........123 N. 2nd Ave., Alpena 49707
Newman, Roy E.....Alpena General Hosp., Alpena 49707
O'Dell, F. C., Jr.......110 W. Chisholm St., Alpena 49707
Parmenter, Elbert S. (L)..316 W. Third, Dixon, Ill. 61021
Philippon, Carlos A.......303 W. Superior St., Alma 48801
Ramsey, J. A.............312 E. Chisholm, Alpena 49707
Ries, Robt. C.........................Rogers City 49779
Riker, John L..........303 N. Second Ave., Alpena 49707
Spens, James E........123 N. Second Ave., Alpena 49707
Stump, G. D................113 State Ave., Alpena 49707
Wagoner, Darwin E............5007 N. Cedar Lake Rd.,
Oscoda 48753
Watkins, T. M.........312 E. Chisholm St., Alpena 49707
Wienczewski, T. W.......919 N. 2nd Ave., Alpena 49707
Wilson, Chas. S. (L).......730 State Ave., Alpena 49707

BARRY COUNTY MEDICAL SOCIETY (18)

irk, Wilbur R. (A)....2113 Arborview, Ann Arbor 48103
lair, Larry..............110 W. Center, Hastings 49058
rown, Jack A..........303 Broadway, Middleville 49333
astleman, Douglas H.....110 W. Center, Hastings 49058
innie, Gordon M..........535 E. Francis, Hastings 49058
innie, Raymond G.........535 E. Francis, Hastings 49058
winn, Alexander B. (L)........1016 San Lucia Dr. SE,
Grand Rapids 49506
easlip, Jos. D. (R)...............13800 83rd Place N.,
Largo, Florida 33540
offs, Marinus A.......911 Fourth St., Lake Odessa 48849
Huebner, R. J............110 W. Center, Hastings 49058
Lofdahl, Stewart (R) R. 1, Box 172, St. Charles, Ill. 60174
Logan, Wesley G........City Bank Bldg., Hastings 49058
Lundeen, John G.....595 Jordan Lake, Lake Odessa 48849
Morrill, Charles E......110 W. Center St., Hastings 49058
Myers, Thos. W.........307 N. Main St., Nashville 49073
Noah, Melvin L.......................Middleville 49333
Phelps, Everett L. (A)..535 E. Francis St., Hastings 49058
Pryor, Robt. B...........400 W. State St., Hastings 49058
Spindler, James R......110 W. Center St., Hastings 49058
Tromp, Jack L..............R. D. 3, Lake Odessa 48849

BAY-ARENAC-IOSCO COUNTY MEDICAL SOCIETY (22)

Alcorn, Kent A.........1420 Center Ave., Bay City 48706
Alcorn, Marshall W.....1420 Center Ave., Bay City 48706
Allen, Arthur D. (L)....101 W. John St., Bay City 48706
Antle, Robert C.........101 W. John St., Bay City 48706
Asbury, Richard B.........2110 16th St., Bay City 48706
Asline, John N........207 N. Walnut St., Bay City 48706
Austin, Justus J. (R).................Tawas City 48763
Bickham, Richard E......101 W. John St., Bay City 48706
Bowman, David A.......101 W. John St., Bay City 48706
Bozdech, Jiri Josef.......900 N. Jackson, Bay City 48706
Brenner, Frederick......1805 Sixth Street, Bay City 48706
Brinkman, Harvey H...116 W. State St., East Tawas 48730
Brown, Geo. M. (L)...207 N. Walnut St., Bay City 48706
Buechle, George T...............175 E. Pinconning Dr., Pinconning 48650
Cajigas, Tomas R....1908 Columbus Ave., Bay City 48706
Campbell, Donald A.........700 Borton, Essexville 48732
Campbell, John S.....1838 McKinley Ave., Bay City 48706
Chapin, Fredk. J. 366 Killarney Beach Rd., Bay City 48706
Cook, Hugh K...........101 W. John St., Bay City 48706
Cook, Raymond R.......1115 Fifth Street, Bay City 48706
Cooper, James C...........410 Hart St., Essexville 48732
Cosens, Stanley A........101 W. John St., Bay City 48706
Crissey, Robt. R.........101 W. John St., Bay City 48706
Criswell, Robt. H. (L)............721 Washington Ave., Bay City 48706
Csonka, Nicholas....1308 Columbus Ave., Bay City 48706
Dardas, Michael J......1413 Center Ave., Bay City 48706
Davis, James H..........1308 Columbus, Bay City 48706
Dolbee, Malcolm K.............Box 518, Standish 48658
Ferguson, Robert........101 W. John St., Bay City 48706
Fischer, Hans.........................Standish 48658
Follis, Wm. M.............101 W. John, Bay City 48706
Gamble, Wm. G., Jr.......2010 5th Ave., Bay City 48706
Gehman, J. R..........................Standish 48658
Geneczko, John T....1102 Columbus Ave., Bay City 48706
Grigg, John W.......2110 Sixteenth St., Bay City 48706
Gueramy, Mono........1411 Center Ave., Bay City 48706
Hafford, Robert C........101 W. John St., Bay City 48706
Hagelshaw, Gayland L....101 W. John St., Bay City 48706
Hess, Chas. L. (R)....305 Leonard Lane, Midland 48640
Heuser, Harold H...916 Washington Ave., Bay City 48706
Horowitz, Saml. F......1415 Center Ave., Bay City 48706
Howland, Walter L......2110 E. 16th St., Bay City 48706
Jacques, J. E........................Tawas City 48763
Jaffe, Martin D..........2110 16th Street, Bay City 48706
Johnson, Orlen J. (L)..207 N. Walnut St., Bay City 48706
Jones, M. Culver........900 N. Jackson, Bay City 48706
Jones, Tyre K., III.......1639 Carla Ct., Essexville 48732
Kelly, Larry Stanley..................Tawas City 48763
Kessler, Mana..........311 Center Ave., Bay City 48706
Kessler-Frux, Sabina....311 Center Ave., Bay City 48706
Knobloch, Howard T.....1102 Columbus, Bay City 48706
Kovacsi, Laszlo...........820 N. Johnson, Bay City 48706
Kulinski, Eugene J.........2110 16th St., Bay City 48706
Lambert, Leslie A...............R 2, East Tawas 48730
Langin, John L.............100 15th St., Bay City 48706
Loan, G. B........Essexville Mdcl. Bldg., Essexville 48732
Loree, Joseph..........1407 Center Ave., Bay City 48706
MacRae, Leonard D.....813 Sherman St., Bay City 48706
Mayne, John C..........101 W. John St., Bay City 48706
McGee, Harry B...........101 W. John, Bay City 48706
McGee, Peter L...........2110 16th St., Bay City 48706
McSherry, Leo B., Jr. 1102 Columbus Ave., Bay City 48706
Medvezky, Michael J.............1106 S. Madison Ave., Bay City 48706
Miller, Edwin C.........101 W. John St., Bay City 48706
Moeller, Arlyn.........700 Borton Ave., Essexville 48732
Moore, Allen B.........700 Borton Ave., Essexville 48732
Moore, Neal R...........704 N. Jackson, Bay City 48706
Mosier, Dwight J.........101 W. John St., Bay City 48706
Parks, Floyd R., Jr.......101 W. John St., Bay City 48706
Payea, Norman P.....217 Newman St., East Tawas 48730
Pearson, Stanley M.......101 W. John St., Bay City 48706
Pederson, B. L........East Medical Bldg., Bay City 48706
Pelczar, Walter E.....321 N. Johnson St., Bay City 48706
Prophater, Robt. C....202 Boehringer Ct., Bay City 48706
Reidinger, Alan A. (M)...................109 Utah St., Dyess AFB, Tex. 79607
Rodda, E. H............101 W. John St., Bay City 48706
Rogers, Charles S........101 W. John St., Bay City 48706
Rowe, Paul W...........Mercy Hospital, Bay City 48706
Salman, Feyyaz.......1221 Orchard Rd., Essevxille 48732
Schmelzer, Wm. J.............602 Mercer St., P.O. 746, Pinconning 48650
Shafer, Harold C........101 W. John St., Bay City 48706
Shields, Hubert L.......101 W. John St., Bay City 48706
Standiford, David.........2110 16th St., Bay City 48706
Stroia, Livius N..........101 W. John St., Bay City 48706
Sutton, R. L., Jr......116 W. State St., East Tawas 48730
Taheri, Zia E.........1411 Center Avenue, Bay City 48706
Tarter, Clyde S. (R)...........Star Route, Alpena 49707
Tompkins, Dana A...................Pinconning 48650
Treadway, Gaylord.......900 N. Jackson, Bay City 48706
Vail, Harry F.......564 W. Hampton Rd., Essexville 48732
Vanasupa, Prabhundha...101 W. John St., Bay City 48706
Way, John H.........903 N. Powell Rd., Essexville 48732
Wilson, Thos. G. (R)..R. 2, Box 112H, Tawas City 48763
Woodburne, Harris L.....1420 Center St., Bay City 48706
Wright, Thomas B.......101 W. John St., Bay City 48706
Zaremba, Aloysius J. (L)..........108 S. Madison Ave., Bay City 48706
Ziliak, Alois L., Jr........3393 Kiesel Rd., Bay City 48706

BERRIEN COUNTY MEDICAL SOCIETY (26)

Asselin, Dean R.......2817 S. State St., St. Joseph 49085
Atkinson, Robert L...1626 Langley Ave., St. Joseph 49085
Bailey, John H...2150 Samuel Ave., Benton Harbor 49022
Beal, Gerald N...Sheperd Benning Bldg., St. Joseph 49085
Benner, Wm. H.....700 Empire Rd., Benton Harbor 49022
Bieri, Dixon L....645 Riverview Dr., Benton Harbor 49022
Bliesmer, August F.....505 Pleasant St., St. Joseph 49085
Bock, William C.....505 Pleasant Street, St. Joseph 49085
Brink, John W...........807 Myrtle St., St. Joseph 49085
Bronfenbrenner, Jack................687 E. Empire Ave., Benton Harbor 49022
Bruni, John R..............1 South Fifth St., Niles 49120
Bunker, Frank H...858 Pipestone St., Benton Harbor 49022
Cadieux, Hale W. 645 Riverview Dr., Benton Harbor 49022
Camp, Donald C.........8 N. St. Joseph Ave., Niles 49120
Carter, John H.................687 E. Empire Avenue, Benton Harbor 49022
Cawthorne, Harold J. (R)...R. 4, Box 201, Coloma 49038
Chickering, Wm. A......2016 Lakeview, St. Joseph 49085
Cilella, S. G.............Pawating Hospital, Niles 49120
Colligan, Joseph (A) University Hospital, Ann Arbor 48104
Conway, Jos..............358 N. Main, Watervliet 49098
Conybeare, Robt. C...756 Pipestone, Benton Harbor 49022
Cooke, Weldon..................Berrien County Hosp., Berrien Center 49102
Cooper, Wm. L.....Rt. 1, Paw Paw Island, Coloma 49038
Crowell, Richard C..................645 Riverview Dr., Benton Harbor 49022
Dailey, Walter S..............122 Grant St., Niles 49120
Dalgleish, Archie J.....460 N. Main St., Watervliet 49098
Doolittle, John E.....9 S. St. Joseph Avenue, Niles 49120
Eidson, Hazel D. (L).............Berrien Springs 49103
Elghammer, Richard M...............1850 Colfax Ave., Benton Harbor 49022
Elliott, J. Colin........802 E. Front St., Buchanan 49107
Emery, Clayton S. (L)..1020 Niles Ave., St. Joseph 49085
Emery, Wm. K.........1020 Niles Ave., St. Joseph 49085
Faber, Michael....756 Pipestone St., Benton Harbor 49022
Fattic, Grover R., Jr.....61 N. St. Joseph Ave., Niles 49120
Feeley, Marshall J......2516 Niles Ave., St. Joseph 49085
Friedman, Morris E.................115 N. Barton St., New Buffalo 49117
Galles, James O........429 Paw Paw Ave., Coloma 49038
Gillette, Clarence (L).....RFD 4, M-60 W, Niles 49120
Gould, Samuel H...1850 Colfax Ave., Benton Harbor 49022
Grayson, Chas. J..........4 Maple St., Three Oaks 49128

Green, Barbara G....2600 Morton Street, St. Joseph 49085
Green, Robt. L......2600 Morton Street, St. Joseph 49085
Grundset, Harold M....61 N. St. Joseph Ave., Niles 49120
Guaty, Nestor C...858 Pipestone St., Benton Harbor 49022
Gustin, Ralph D.....P.O. Box 159, Berrien Springs 49103
Haight, Arthur S. 645 Riverview Dr., Benton Harbor 49022
Hassan, D. Kent........802 E. Front St., Buchanan 49107
Haupt, Edward C...687 E. Empire, Benton Harbor 49022
Hayes, Thos. P. (A)............Univ. of Pa. Grad Hosp., 19th and Lombard, Philadelphia, Pa. 19146
Henderson, Fred C.............703 E. Main, Niles 49120
Hershey, Noel J...............P.O. Box 222, Niles 49120
Hills, David W...........2821 State St., St. Joseph 49085
Howard, Frank W....756 Pipestone, Benton Harbor 49022
Hudnutt, Dean..........807 Myrtle St., St. Joseph 49085
Huff, Harold D...............126 Main St., Niles 49120
Irgens, Edwin R. 11 Peoples St. Bk. Bldg., St. Joseph 49085
Johnston, Wm. H........715 Market St., St. Joseph 49085
Kelsall, Harvey I........1600 Niles Ave., St. Joseph 49085
Kenfield, W. J. (A).....505 Pleasant St., St. Joseph 49085
Kennedy, F. Alan 315 Fidelity Bldg., Benton Harbor 49022
Kilic, Orhan.............8 N. St. Joseph St., Niles 49120
King, Frank A., Jr....858 Pipestone, Benton Horbor 49022
Klos, Henry J......2700 Highland Ct., St. Joseph 49085
Landgraf, Robt. L.............P.O. Box 222, Niles 49120
Learned, David W...................645 Riverview Dr., Benton Harbor 49022
Lee, Hai Soon........711 Beechwood Drive, Niles 49120
Leva, John B......1122 Salem Ave., Benton Harbor 49022
Lindenfeld, Fredk. H....8 N. St. Joseph Ave., Niles 49120
Lininger, Richard E...2712 Highland Ct., St. Joseph 49085
Linn, Frank...............2522 Niles, St. Joseph 49085
Locey, Robert P.................164 Higman Park Rd., Benton Harbor 49022
Macias, Rafael.........8 N. St. Joseph Ave.. Niles 49120
Manning, John T...1150 Miami Rd., Benton Harbor 49022
McDonald, James L.....2516 Niles Ave.. St. Joseph 49085
McLelland, J. T...............Mercy Hosp. X-ray Dept., Benton Harbor 49022
Mesirow, Stanley M................687 E. Empire Ave., Benton Harbor 49022
Moore, T. Scott...............P.O. Box 416, Niles 49120
Namtze, Chan................1111 Oak St., Niles 49120
O'Toole, John.......133 E. Napier, Benton Harbor 49022
Ozeran, Chas. J.......127 E. Napier, Benton Harbor 49022
Padelford, Wm. J.....................South Lyon 48178
Payne, Charles E...925 Pipestone St., Benton Harbor 49022
Peshka, David K.......61 N. St. Joseph Ave., Niles 49120
Polansky, Sanford...84 W. Main St., Benton Harbor 49022
Porter, Chas. B...1589 Colfax Ave., Benton Harbor 49022
Quadir, Syed A.......928 Dewey Ave., Kalamazoo 49001
Rambo, Joseph J..........555 Lake St., Bridgman 49106
Ray, Dean K...............2522 Niles, St. Joseph 49085
Reagan, Robt. E.......232 Windsor, Benton Harbor 49022
Rizzo, Albert....415 Fidelity Bldg., Benton Harbor 49022
Ruth, J. Griswold..1304 Seneca Rd., Benton Harbor 49022
Skinner, James W.....460 Ridgeway St., St. Joseph 49085
Smith, W. B.........133 E. Napier, Benton Harbor 49022
Sori, Manuel R....858 Pipestone St., Benton Harbor 49022
Sowers, Bouton F. (A)...............236 Higman Park, Benton Harbor 49022
Strayer, John W...............P.O. Box 222, Niles 49120
Stulik, Chas. K. (L)........Town Line Rd., P.O. Box 98, Union Pier 49129
Turner, John J.........2817 S. State St., St. Joseph 49085
Urist, Maurice D...454 Pipestone St., Benton Harbor 49022
Valantiejus, John A.............R.R. 2, Cedar Lane Farm, New Buffalo 49117
Vasquez, Andres H.............Chikaming Medical Ctr., Harbert 49115
Vastine, Russell J., Jr....430 W. Chicago, Buchanan 49107
Westervelt, H. O. (L)..539 Pearl St., Benton Harbor 49022
Willson, Dean........756 Pipestone, Benton Harbor 49022
Wilson, Clinton W. 925 Pipestone St., Benton Harbor 49022
Wise, Warren A........505 Pleasant St., St. Joseph 49085
Woodford, Hackley E...599 E. Main, Benton Harbor 49022
Zick, Luther H.........2522 Niles Ave., St. Joseph 49085

BRANCH COUNTY MEDICAL SOCIETY (30)

Aldrich, Napier S.......162 Marshall St., Coldwater 49036
Bacon, Charles R.....300 E. Chicago St., Coldwater 49036
Bailey, James E., Jr...300 E. Chicago St., Coldwater 49036
Beatty, James B......300 E. Chicago St., Coldwater 49036
Burke, James M...........................R. 4, Coldwater 49036
Coates, Carl A....135 Stringtown, R.F.D. 1, Quincy 49082
Culver, Dean T......173 E. Chicago St., Coldwater 49036
Fraser, Robt. J..........22 W. Pearl St., Coldwater 49036
Geib. Ormond D...State Home Tng. Sch., Coldwater 49036
Gift, Jack...........274 E. Chicago St.. Coldwater 49036
Gomley, Henry C......108 E. Chicago St., Bronson 49028
Heffelfinger, John C................292 E. Chicago Ave., Coldwater 49036
Hoeksema. Ronald H. 292 E. Chicago St., Coldwater 49036
Leitch, Robt. M..........401 Ann St., Union City 49094
Meier, Harold J. (L)....87 W. Pearl St., Coldwater 49036
Mooi, Henry R.......292 E. Chicago St., Coldwater 49036
Moss, Harvey L..............47 Carlyle, Coldwater 49036
Nettleman, Wm. E......87 W. Pearl St., Coldwater 49036
Olmsted, Kenneth L.......675 Monroe, Coldwater 49036
Rennell, Edwin J. Coldwater State Home, Coldwater 49036
Rick, John J...........61 E. Chicago St., Coldwater 49036
Schillinger, H. K..............Box 148, Coldwater 49036
Stewart, William K........403 Ann St., Union City 49094
Thomas, James A.....390 E. Chicago St., Coldwater 49036
Tschetter, David J...........4112 97th Court, Apt. 104, Oaklawn, Ill. 60453
Walton, Nathaniel J...........Box 148, Coldwater 49036
Weidner, Harold R......50 Division St., Coldwater 49036
Wise, Robert..State Hm. & Trng. School, Coldwater 49036

CALHOUN COUNTY MEDICAL SOCIETY (34)

Albright, Arnold A......R. 1, Box 300, Battle Creek 49014
Allen, R. H.............191 College, Battle Creek 49017
Amos, Norman H...710 North Avenue, Battle Creek 49017
Amos, Norman O...710 North Avenue, Battle Creek 49017
Anderson, Harold E..................501 Post Building, Battle Creek 49017
Azuela, Victor....124 Lakeview Ave., Battle Creek 49015
Bakken, Richard L....200 College St., Battle Creek 49017
Barden, Stuart P.........Leila Hosp., Battle Creek 49014
Baribeau, Roy H. (L)...........65 N. Michigan Ave., Battle Creek 49014
Bartels, George H...710 North Avenue, Battle Creek 49017
Becker, Harry F. (L)........Box 547, Battle Creek
Berghorst, John (A)....VA Hospital, Battle Creek 49016
Bonifer, Philip P......231 North Ave., Battle Creek 49017
Bonifer, Philip P., Jr..............401 Security Bk. Bldg., Battle Creek 49014
Boswell, David E....105 N. Jefferson Ave., Marshall 49068
Brown, Robt. W....231 North Avenue, Battle Creek 49017
Buell, Martin F. (A)....V. A. Hospital, Ft. Custer 49016
Campbell, Alice F.......103 E. Mulberry St., Albion 49224
Campbell, Jack S.....1018 North Ave., Battle Creek 49017
Campbell, Richard J.....154 West St., Battle Creek 49017
Capron, M. J., Jr.................806 Security Bk. Bldg., Battle Creek 49014
Caviness, L. Harold.................185 N. Washington, Battle Creek 49017
Chandler, Edward M..........411 Mich. Nat. Bk. Bldg., Battle Creek 49014
Chynoweth, Wm. R. (L)................207 Post Bldg., Battle Creek 49017
Coakes, Jack E. (A)......716 Gorham St., Marshall 49068
Colquhoun, Graham F. 188 College St., Battle Creek 49017
Cram, Ralph A............500 S. Ionia St., Albion 49224
Curry, Robt. K..........................Homer 49245
Daly, Harold L., Jr.........500 S. Ionia St., Albion 49224
Daly, Mary.......................Box 7, Albion 49224
Daly, Miriam S............500 S. Ionia St., Albion 49224
Diamante, Paul J...710 North Avenue, Battle Creek 49017

Dickson, Albert R. (L)..............250 Champion St., Battle Creek 49017
Dodge, Warren M., Jr. (R)..............75 Laurel Dr., Battle Creek 49017
Fairbanks, Stephen........306 S. Superior, Albion 49224
Ferazzi, Patrick S....1018 North Ave., Battle Creek 49017
Finch, Duward L.................719 Capital Ave. SW., Battle Creek 49015
Fisher, Robt. E.................1501 W. Michigan Ave., Battle Creek 49017
Fraser, Robt. H. (L)..............25 W. Michigan Ave., Battle Creek 49014
Funk, L. D..............133 W. Burr Oak, Athens 49011
Giddings, A. M. (L) 103 Dicker Pl., St. Marys, OH 45885
Gieser, E. Paul, Jr..........407 Alton, Battle Creek 49017
Gilfillan, Margery J. (L)..............125 56th Ave S., St. Petersburg, Fl. 33708
Girardot, John C.....25 W. Michigan, Battle Creek 49014
Glotfelty, Philip R.....219 N. Madison St., Marshall 49068
Gough, Joseph G...............American Legion Hosp., Battle Creek 49014
Craubner, Franklin L. Bogar Theater Bldg., Marshall 49068
Gray, J. Alan................309 Mich. Natl. Bk. Bldg., Battle Creek 49014
Green, Harold E......175 College St., Battle Creek 49017
Griffith, Jack C..............616 Mich. Nat. Bnk. Bldg., Battle Creek 49014
Halac, Mehmet E.....163 North Ave., Battle Creek 49017
Hamady, Alfred.....1018 North Ave., Battle Creek 49017
Hansen, Edwin L.....216 North Ave., Battle Creek 49017
Hansen, Harvey C...............65 W. Michigan Ave., Battle Creek 49014
Henderson, Philip M..........109 W. Erie, Albion 49224
Henriksen, J. D..........4 Hiawatha, Battle Creek 49015
Hibbs, Donald K...117 Sunnyside Dr., Battle Creek 49015
Hickman, Marjorie J. (A)................147 Viking Ct., Battle Creek 49017
Holtom, Benj. G...815 Security Tower, Battle Creek 49014
Hooker, Lyle T. (A)....V.A. Hospital, Battle Creek 49016
Hubly, James W..................777 SE Second Ave., Deerfield Beach, Fl. 33441
Humphrey, Archie E...122 N. Madison St., Marshall 49068
Humphrey, Arthur A...175 College St., Battle Creek 49017
Humphrey, Herbert E. 122 N. Madison St., Marshall 49068
Huntington, John.....710 North Ave., Battle Creek 49017
Jacobson, Dwight................411 Mich. Natl. Bank, Battle Creek 49014
Jeffrey, James R. (L)..........179 N. Washington Ave., Battle Creek 49017
Johnson, Melvin, Jr.....Leila Hospital, Battle Creek 49014
Jones, Aubrey H. (A)....V. A. Hospital, Ft. Custer 49016
Jones, Ernest F. (A)—175 Island Ave., Battle Creek 49017
Jones, Tyre K.............118 W. Green, Marshall 49068
Kelleher, George T....235 North Ave., Battle Creek 49017
Kinde, Matthew R. (A)................400 North Ave., Battle Creek 49017
Kingsley, Paul C.........191 College, Battle Creek 49017
Klopp, Edward J.......173 College St., Battle Creek 49017
Lakke, Gordon W...710 North Avenue, Battle Creek 49017
Lam, Francis L...408 Capital Ave. SW, Battle Creek 49015
Lancaster, Vance B....710 North Ave., Battle Creek 49017
Lanuti, Frank..........R. 3, Box 46 A, Battle Creek 49017
Levy, Jos., Jr........231 North Ave., Battle Creek 49017
Lewis, Welcome B. (L)..........196 Irving Park Drive., Battle Creek 49017
Long, Walter B..........................Homer 49245
Lowe, Kenneth H.....231 North Ave., Battle Creek 49017
Lowe, Stanley T. (R)................12 Hiawatha Dr., Battle Creek 49015
Lund, C. A. E.....135 Hamblin Ave., Battle Creek 49014
Maurer, James J...............616 Mich. Natl. Bk. Bldg., Battle Creek 49014
McCuaig, Alfred C.................719 Capital St. SW., Battle Creek 49015
McGee, John W............105 Irwin Ave., Albion 49224
Melges, Fredk. J..................25 W. Michigan Ave., Battle Creek 49014
Moir, Hugh K. (A).....V.A. Hospital, Battle Creek 49016
Morrison, Donald B...719 Capital S.W., Battle Creek 49015
Mullenmeister, H. F...275 Capital N.E., Battle Creek 49017
Murillo, Casmir....235 North Avenue, Battle Creek 49017
Norgan, Anne F.................719 Capital Ave. S.W., Battle Creek 49015
Patrick, Gilbert T.................25 W. Michigan Ave., Battle Creek 49014
Patt, Albert J...........154 West St., Battle Creek 49017
Pearson, Donald J.....255 North Ave., Battle Creek 49017
Pier, Clarence T. (A)...80 Griffin Ct., Battle Creek 49015
Pipe, Lawrence D. (M) Leila Hospital, Battle Creek 49014
Powell, C. E.........632 North Ave., Battle Creek 49017
Powell, Donna (A)......V. A. Hospital, Ft. Custer 49016
Power, John R..........154 West St., Battle Creek 49017
Robbert, John...........191 College, Battle Creek 49017
Roberge, Jerome T..............1001 Security Bk. Bldg., Battle Creek 49014
Rorich, Wilma C. W. (R) 86 Oaklawn, Battle Creek 49017
Rowan, Russell C..........500 S. Ionia St., Albion 49224
Royer, Clark W.................1331 W. Michigan Ave., Battle Creek 49017
Ryan, Chas. J............Leila Hosp., Battle Creek 49014
Seifert, Charles (M)..................6231 Peace Pipe, San Antonio, Tx. 78238
Sevidal, Pedro A., Jr...1018 North Ave., Battle Creek 49017
Sharp, Ara D. (R).........502 Irwin Ave., Albion 49224
Shellenberger, H. M. (R)..123 S. Jefferson, Marshall 49068
Shipp, Leland P. 25 W. Michigan Ave., Battle Creek 49014
Sibilsky, A. Clark (A)................281 Honey Lane, Battle Creek 49015
Simpson, Robt. S................700 Capital Ave. S.W., Battle Creek 49015
Slagle, Ceo. W. (L)............203 Capital Ave. N.E., Battle Creek 49017
Spencer, Collis M......308½ S. Superior St., Albion 49224
Stadle, Wendall H. (R)..........607 Jennings Landing, Cougac Lake, Battle Creek 49014
Stephenson, C. D.......154 West St., Battle Creek 49017
Stiefel, Richard A.................25 W. Michigan Ave., Battle Creek 49014
Strohmenger, Frank J..........500 S. Ionia, Albion 49224
Taylor, Clifford B..........500 S. Ionia St., Albion 49224
Tazelaar, Myron A....219 N. Madison St., Marshall 49068
Thompson, Walter C..............Battle Creek Htl. Ctr., Battle Creek 49014
Vander Kamp, Harry (A) V.A. Hospital, Battle Creek 49016
Vander Voort, Wm. V. (L).........R. 4, Hastings 49058
Verity, Lloyd E. (R)..36 Parkside Dr., Battle Creek 49017
Vetne, Gunnar......725 Capital S.W., Battle Creek 49015
Walker, Chas. S..................709 W. Van Buren St., Battle Creek 49017
Walters, John F.......163 North Ave., Battle Creek 49017
Walters, Wm. D.......175 College St., Battle Creek 49017
Wemmer, Keith S..............1472 W. Michigan Ave., Battle Creek 49017
Wencke, Carl G. (L)..112 Brewer Dr., Battle Creek 49015
Winslow, Sherwood B. 710 North Ave., Battle Creek 49017
Worgess, Duane R................799 Capital Ave. N.E., Battle Creek 49017
Yannitelli, S. A........710 North Ave., Battle Creek 49017
Young, John R...719 Capital Ave. S.W., Battle Creek 49015
Zaplitny, R. B.......1018 North Ave., Battle Creek 49017
Zaplitny, Sophia (A)..R. 3, Box G5 A, Battle Creek 49017
Zhentlin, Bertram......50 Adams St., Battle Creek 49015
Zindler, Ceo. A...............1201 Security Bnk. Bldg., Battle Creek 49014

CASS COUNTY MEDICAL SOCIETY (38)

Adams, Uriah M........................Marcellus 49067
Clary, Rudolph I........216 S. Front St., Dowagiac 49047
Comstock, L. David, Jr...417 W. High St., Dowagiac 49047
Guzzo, Henry V....515 Main St., Suite 1, Dowagiac 49047
Hickman, John K....108 W. Division St., Dowagiac 49047
Loupee, Sherman L. (L)...108 Orchard, Dowagiac 49047
Pierce, Kenneth C......417 W. High St., Dowagiac 49047
Warren, Aaron K........109 School St., Cassopolis 49031

CHIPPEWA-MACKINAC COUNTY MEDICAL SOCIETY (42)

Allott, Hugh R. (A)....................816 Ashmun St., Sault Ste. Marie 49783
Blair, H. Milton.....300 Court St., Sault Ste. Marie 49783
Clausen, Claire H. (L)..........................300 Court St., Sault Ste. Marie 49783
Coulter, Wm. J..................Drummond Island 49726
Finlayson, Donald D..................301 E. Spruce St., Sault Ste. Marie 49783
Hagele, Marie A......126 Park Pl., Sault Ste. Marie 49783
Hamel, Herbert E......................St. Ignace 49781
Harrington, Harvey M. (L)..................Box 319, Sault Ste. Marie 49783
Heilman, Robert D................War Memorial Hosp., Sault Ste. Marie 49783
Howe, Donnell C., Jr. 300 Court St., Sault Ste. Marie 49783
Mackie, Thos. B......300 Court St., Sault Ste Marie 49783
McBryde, Lyman M....................416 Ashmun St., Sault Ste. Marie 49783
Mertaugh, Wm. F..................104 W. Spruce St., Sault Ste. Marie 49783
Montgomery, Benj. T. (L)................P. O. Box 39, Sault Ste. Marie 49783
Reddick, C. E.................Chippewa Co. Htl. Dept., Sault Ste. Marie 49783
Rhind, Earl S.....Sault Polyclinic, Sault Ste. Marie 49783
Scott, Dale.......816 Ashmun St., Sault Ste. Marie 49783
Solomon, Joseph A...............Mackinac Island 49757
Thompson, Chas. F. (L)........Drummond Island 49726
Trapasso, Tony J.....816 Ashmun, Sault Ste. Marie 49783
Tygart, Robert L....301 E. Spruce, Sault Ste. Marie 49783
Venier, Anton G...816 Ashmun St., Sault Ste. Marie 49783
Wedding, Erling S.....................203 Hudson Dr., Sault Ste Marie 49783

CLINTON COUNTY MEDICAL SOCIETY (46)

Bennett, Geo. W...........203 W. Main St., Elsie 48831
Cook, Bruno C......................Westphalia 48894
Filiinger, Wells B. (L)......................Ovid 48866
Foo, Chas. T. (L)..1716 30th St. W., Bradenton, Fl. 33505
Grost, James M............Park Avenue, St. Johns 48879
Henthorn, Arthur C. (L).......Box 216, St. Johns 48879
Russell, Sherwood R...104 N. Oakland St., St. Johns 48879
Scott, James S..........................DeWitt 48820
Sheline, Victor L...........Medical Center, Ithaca 48847
Slagh, Earl M..............................Elsie 48831
Smith, Franklin W.......205 W. State St., St. Johns 48879
Stephenson, Wesley F...510 E. Walker St., St. Johns 48879
Stoller, Paul F........................St. Johns 48879

DELTA-SCHOOLCRAFT COUNTY MEDICAL SOCIETY (50)

Anderson, Francis C......218 S. 10th St., Escanaba 49829
Bernier, A. B.........624 Ludington St., Escanaba 49829
Bash, Theodore L......................Bark River 49807
Benson, Gilbert W. (A)....Ludington St., Escanaba 49829
Berry, Roland E........St. Francis Hosp., Escanaba 49829
Cretens, Mary............Delta-Menominee Hlth. Dept., Escanaba 49829
Dehlin, James R...........8 S. 11th St., Gladstone 49837
Fitch, Donald N...........Doctor's Park, Escanaba 49829
Fyvie, James H.......202 S. Cedar St., Manistique 49854
Gordon, E. James.......117 N. 22nd St., Escanaba 49829
Groos, Harold Q........1015 S. 1st Ave., Escanaba 49829
Groos, Louis P..........1015 S. 1st Ave., Escanaba 49829
Hockstad, Raymond.......Doctor's Park, Escanaba 49829
Hult, Otto S...........1005 Delta Ave., Gladstone 49837
LaSorsa, Armand M..................Manistique 49854
Le Mire, Donald F.....1104 S. First Ave., Escanaba 49829
Le Mire, William A....1106 First Ave. S., Escanaba 49829
Maniaci, Geo...........8 South 11th St., Gladstone 49837
McInerney, Thos. A...1221 Ludington St., Escanaba 49829
Olson, Carl J..............8 S. 11th St., Gladstone 49837
Ryde, Robt. E...........1221 Ludington, Escanaba 49829
Sayani, Ian.........Bay View Location, Gladstone 49837
Theisen, Nikolaus J...1400 16th Avenue S., Escanaba 49829
Waters, Duane L.......200 S. Cedar St., Manistique 49854
Wehner, Merle E.........131 River St., Manistique 49854
Whipple, Arno......117 North 22nd St., Escanaba 49829

DICKINSON-IRON COUNTY MEDICAL SOICETY (54)

Addison, Earl R....412 Superior Ave., Crystal Falls 49920
Alexander, Wm. H. (L)................411 East C St., Iron Mountain 49801
Anderson, Donald T...408 Hamilton Ave., Kingsford 49801
Boyce, George H. (L)............First Natl. Bank Bldg., Iron Mountain 49801
Boyce, George H., Jr. (A)............700 Hamilton Ave., Kingsford 49801
Carlson, Ralph E..................500 Stephenson Ave., Iron Mountain 49801
Cecconi, R. D..................Commercial Bank Bldg., Iron Mountain 49801
Cooper, Chas. A..............Box 542, Stambaugh 49964
Gendzwell, Joyce..805 Vulcan Street, Iron Mountain 49801
Gladstone, Wm. R., Jr.......804 Main St., Norway 49870
Gorham, Arwin Nevada State Hospital, Nevada, Mo. 64772
Hayes, Willard N.........720 N. Main St., Norway 49870
Huron, Willis H.....106 West B St., Iron Mountain 49801
Irvine, Lionel E. (L)..........Box 438, Iron River 49935
Jacobs, Donald J...Professional Bldg., Iron Mountain 49801
Kofmehl, Wm. J. (L).................Stambaugh 49964
McEachran, Hugh D..............500 Stephenson Ave., Iron Mountain 49801
Newkirk, John A......Khoury Bldg., Iron Mountain 49801
Nora, James C..........15 Eighth Ave., Iron River 49935
Pieper, Ernest....................Iron Mountain 49801
Retallack, Russell C...326 W. Genesee St., Iron River 49935
Roberts, Warren J. (A)............1020 Carpenter Ave., Iron Mountain 49801
Schmutzler, Walter A..................373 Woodward St., Iron Mountain 49801
Schroeder, John M.....Khoury Bldg., Iron Mountain 49801
Sherk, Douglas..........412 Superior, Crystal Falls 49920
Smith, Donald R...........Box 471, Iron Mountain 49801
Steinke, Chas. G..................517 Stephenson Ave., Iron Mountain 49801
Stelle, Robert E.........412 Superior, Crystal Falls 49920
Trump, Paul L.............808 Terrace, Kingsford 49801
Wollum, Arnold (A)................R. 1, Vulcan 49892

EATON COUNTY MEDICAL SOCIETY (58)

Berg, Richard H...........162 Second St., Sunfield 48890
Brown, Byron P..........339 S. Cochran, Charlotte 48813
Butler, Vernon C........201 Marilin, Eaton Rapids 48827
Carothers, Danl. J........125 Lansing St., Charlotte 48813
Curtis, Keith L..........202 S. Cochran, Charlotte 48813
De Land, C. Le Roy.........................Olivet 49076
Engle, Paul H. (A).........................Olivet 49076
Erhard, O. Stewart......301 Rancho, Eaton Rapids 48827
Garlock, Fred C...406 E. Jefferson St., Grand Ledge 48837
Harrod, Gordon R..................Grand Ledge 48837
Joseph, Daniel D...........R. 1, Box 25, Charlotte 48813
Meinke, Albert H., Jr..............800 Cumberland Dr., Eaton Rapids 48827
Myers, Albert W......................Potterville 48876
Passos, Benjamin A...304 N. Cochran Ave., Charlotte 48813
Riley, Jos. L..........201 S. Cochran St., Charlotte 48813
Robinson, S. R.......1140 Willow St., Grand Ledge 48837
Sevener, Lester G.........236 S. Main St., Charlotte 48813
Sherman, Eber B.....501 Carlisle St., Eaton Rapids 48827
Van Ark, Bert..............511 Hale, Eaton Rapids 48827
Van Ark, Herman F.....410 Blake St., Eaton Rapids 48827
Willits, Clayton O..........127 Upland, Charlotte 48813

GENESEE COUNTY MEDICAL SOCIETY (62)

Abbott, R. Roderick....420 S. Ballenger Hwy., Flint 48504
Adams, Albert C............5210 Lapeer Rd., Flint 48503
Adams, Burnell H..........609 S. Lynch St., Flint 48503
Anderson, Harley H...11820 N. Saginaw, Mt. Morris 48458
Anderson, John L.........2765 Flushing Rd., Flint 48504
Antell, Richard A........2733 Crestwood Dr., Flint 48503
Anthony, Geo. E. R.........1015 Detroit St., Flint 48503
Baird, W. Claire..........2765 Flushing Rd., Flint 48504
Bald, Fredk. W............410 S. Ballenger, Flint 48504
Barbour, David A............5369 Briarcrest, Flint 48504
Barbour, Fleming A........2015 Lincoln Dr., Flint 48503
Baske, Franklin W...........923 Maxine St., Flint 48503
Batdorf, Joseph T...11325 S. Saginaw, Grand Blanc 48439
Bateman, Lawrence G.........1928 Lewis St., Flint 48506
Beck, Douglass R.....1450 Country View Ln., Flint 48504
Becker, Eugene B.........2765 Flushing Rd., Flint 48504
Benkert, Jack...6211 Lake Forest Dr., Grand Blanc 48439
Benson, John C.........639 Mott Fdtn. Bldg., Flint 48502
Berman, Harry............3309 Fenton Rd., Flint 48507
Berner, Gerald P..........2765 Flushing Rd., Flint 48504
Bernstein, Eli N............311 E. Court St., Flint 48503
Berry, Robert E. L.....715 Mott Fdtn. Bldg., Flint 48502
Best, J. A....................3803 Clio Rd., Flint 48504
Beyer, Geo. D.............G 3337 W. Vienna, Clio 48420
Biedlingmaier, G. J.................12511 Via Catherina, Grand Blanc 48439
Bogart, Leon M. (L).....503 National Bldg., Flint 48502
Bolduc, Gregoire............325 E. First St., Flint 48502
Boles, Wm. P. (L)............714 Beach St., Flint 48502
Bonet, Virgilio...........2765 Flushing Rd., Flint 48504
Bosker, Donald............1620 N. Franklin, Flint 48506
Bota, Robert A..............1623 Montclair, Flint 48503
Boyer, Peter R........100 Medical Arts Bldg., Flint 48501
Bradley, Robt. M.......1112 Mott Fnd. Bldg., Flint 48502
Brady, John L.........710 Mott Fdtn. Bldg., Flint 48502
Brain, Roy G. (L)........460 S. Saginaw St., Flint 48502
Branch, Hira E.........821 Mott Fdtn. Bldg., Flint 48502
Brasie, Donald R. (R)...R. 2, Box 436, Roscommon 48653
Briggs, Guy D. (L).........224 E. Court St., Flint 48503
Brown, Clarence A.....926 Mott Fdtn. Bldg., Flint 48502
Bryant, Donald R.......621 Mott Fdtn. Bldg., Flint 48502
Buchanan, Gerald S.......211 S. Saginaw St., Holly 48442
Buchanan, Wm. F.........238 W. Caroline, Fenton 48430
Burkett, Leslie V..........618 Dougherty Pl., Flint 48504
Canada, Donald R....1207 N. Ballenger Hwy., Flint 48504
Canas, Robert R..........G 3404 Miller Rd., Flint 48507
Carter, Norman A.......739 Mott Fdtn. Bldg., Flint 48502
Chambers, Myrton S...3402 Westwood Pkwy., Flint 48503
Chardoul, Eugene N.......202 Paterson Bldg., Flint 48502
Chase, Wm. D.......1318 N. Ballenger Hwy., Flint 48504
Chogich, John C............1245 Dupont St., Flint 48504
Clark, Robt. L............1301 Flushing Rd., Flint 48504
Cole, Gerald G.........1818 Longway Blvd., Flint 48501
Collie, Ross J...............1812 E. 2nd St., Flint 48503
Collins, James I..........G 1128 N. Dye Road, Flint 48504
Colwell, Clifford W.......328 S. Saginaw St., Flint 48502
Congdon, David E............2630 Sloan St., Flint 48504
Conover, Geo. V.......625 S. Grand Traverse, Flint 48503
Conover, McClellan B...625 S. Grand Traverse, Flint 48503
Cook, Frank W............410 S. Ballenger, Flint 48504
Cook, Henry (L)....208 Genesee Bank Bldg., Flint 48502
Cook, John L........208 Genesee Bank Bldg., Flint 48502
Cookingham, Cory E.....208 Med. Arts. Bldg., Flint 48501
Coriasso, Louis B......1515 W. Atherton Rd., Flint 48507
Coyne, Kenneth M...........325 E. First St., Flint 48503
Cross, Robert L..................6029 Marja, Flint 48505
Curry, Geo. J. (L)....................8411 Lagoon Rd., Ft. Myers Beach, Fl. 33931
Cutler, G. Campbell........420 S. Ballenger, Flint 48504
Damm, John R........8483 Holly Rd., Grand Blanc 48439
Davis, Robt. C...........G 3029 Flushing Rd., Flint 48504
Dawson, Ralph E.........721 W. Sixth Ave., Flint 48503
Day, John Murray..........315 E. Court St., Flint 48503
Delzingro, Nicholas (L).....328 Main St., Davison 48423
Dettman, Carlton K...12023 N. Seymour, Montrose 48457
Dickstein, Bernard........605 National Bldg., Flint 48502
Diggs, Roy D., Jr.......4250 N. Saginaw St., Flint 48505
Dismond, Samuel R......1402 S. Saginaw St., Flint 48503
Dodds, Fredk. E. (L)........1336 Lewis St., Flint 48506
Dodds, Max E........625 S. Grand Traverse, Flint 48503
Dooley, James F.................6479 Carriage Hill Dr., Grand Blanc 48439
Dwyer, William F.....625 S. Grand Traverse, Flint 48503
Dykewicz, Richard A......2744 Flushing Rd., Flint 48504
Eaton, Wayne L........926 Mott Fdtn. Bldg., Flint 48502
Eichhorn, Ernest M.......2765 Flushing Rd., Flint 48504
Eickhorst, Thos. N........2765 Flushing Rd., Flint 48504
Ekinci, Mehmet 2279 Grand Blanc Rd., Grand Blanc 48439
Elliott, Hardie B..........503 S. Saginaw St., Flint 48502
Engelman, Raymond M........2744 Flushing, Flint 48504
Ergin, Nevit........1207 N. Ballenger Hwy., Flint 48504
Ettinger, Ralph D.....238 W. Caroline St., Fenton 48430
Failing, John F., Jr.........Hurley Hospital, Flint 48502
Fan, Q. C...............2002 E. Court St., Flint 48503
Farah, Ben S.............2765 Flushing Rd., Flint 48504
Farhat, Maynard M.........505 W. Court St., Flint 48503
Fee, Manson G...........108 E. Kearsley St., Flint 48502
Fernandez, Jose A.........2765 Flushing Rd., Flint 48504
Ferris, James W...............1005 Leith St., Flint 48505
Finkelstein, Theo.......1415 Broadway Blvd., Flint 48506
Fitch, Robert E..................1005 Leith, Flint 48505
Forrer, Graydon R.............2279 E. Grand Blanc Rd., Grand Blanc 48439
Friedman, Leon..........2765 Flushing Rd., Flint 48504
Fuller, Harvey T. (R)................2700 N. Hayden, Scottsdale, Az. 85257
Gerras, George Z.........1909 Lynbrook Dr., Flint 48507
Gibbons, James J.....101 Medical Arts Bldg., Flint 48501
Goetz, Margarete M. (A)..213 Paterson Bldg., Flint 48502
Goetz, Rudolph..........1221 Church Street, Flint 48503
Goldberg, E. Marshall.......Hurley Hospital, Flint 48502
Golden, Evelyn.............218 E. Court St., Flint 48503
Golden, H. Maxwell.........218 E. Court St., Flint 48503
Gorne, Saul S...............619 Clifford St., Flint 48503
Griffin, Ernest P., Jr........1505 Arrow Lane, Flint 48507
Grommons, Jack R.........721 W. Sixth Ave., Flint 48503
Grover, Harold F. (L)....601 S. Saginaw St., Flint 48502
Gullekson, Edwin H. (A)..2765 Flushing Rd., Flint 48504
Gumpper, C. R.....4437 Morrish Rd., Swartz Creek 48473
Gundry, Geo. L. (L)..11736 Saginaw, Grand Blanc 48439
Gutow, Julius J...........726 Church Street, Flint 48503
Gutow, Isadore H.........2765 Flushing Rd., Flint 48504
Gutow, Richard F. (A) P. O. Box 6085, Denver, Co. 80240
Gutowitz, Erwin......420 S. Ballenger Hwy., Flint 48504
Hackley, Richard D...........1818 R. T. Longway Blvd., Flint 48501
Hague, Robt. F. (L)......8231 River Rd., Flushing 48433
Hallitt, John Wm.....102 Medical Arts Bldg., Flint 48501
Harper, Robt. H.............713 Thomson St., Flint 48503
Harris, Bernard J.............1750 Lynbrook, Flint 84507
Harris, Donald R.........2429 Welch Blvd., Frint 48504
Hauser, Fredk. V......1015 Mott Fdtn. Bldg., Flint 48502
Hawkins, James E..........4618 Roberts St., Flint 48501
Heine, John...........302 Medical Arts Bldg., Flint 48501
Heinemann, Herman J.....G7316 Calkins Rd., Flint 48504
Helcher, Phyllis O.....G5303 Flushing Rd., Flushing 48433
Helferty, Robert D.....1116 Ann Arbor Street, Flint 48503
Helmer, Fredric A. (A)................275 Kings Point. Great Neck. L.I., N.Y. 11024
Hennessy, Charles R.....517 Mott Fdtn. Bldg., Flint 48502
Hiscock, Harold H. (L)..........1315 Mott Fdtn. Bldg.. Flint 48502
Hockman, Thomas A.............11125 Old Bridge Rd., Grand Blanc 48439
Hodges. Frank V............Hurley Hospital, Flint 48502
Hollis, John W.............4300 S. Saginaw, Flint 48507
Hooper, Virgil R.............4230 Trumbull, Flint 48504
Honse, Robert J........5481 Sugarbush Lane, Flint 48504
Hubbard, Wm. B...........1205 Maxine St., Flint 48503
Hubbard, Wm. C. .....302 Paterson Building, Flint 48502
Hufton, Wilfrid L.........2765 Flushing Rd., Flint 48504
Hunt, Richard J. 6259 Lake Forest Dr., Grand Blanc 48439
Hurd, Clayton E...........205 Lincoln St., Fenton 48430
Irish, Lawrence R..........346 Allendale Pl., Flint 48503
Jacoby, John S..........4300 S. Saginaw St., Flint 48507
James, Robt. E............1515 W. Atherton, Flint 48507
Janke, Walter H........603 Mott Fdtn. Bldg., Flint 48502
Johnson, A. H., Jr.............3219 North St., Flint 48505
Johnson, Frank D......625 S. Grand Traverse, Flint 48503

Johnson, Raymond E..................5173 W. Reid Rd., Swartz Creek 48473
Judd, Alvin E..............1620 N. Franklin, Flint 48506
Karr, Paul H................3416 Lapeer Rd., Flint 48503
Kaufman, Lewis D........4002 N. Saginaw St., Flint 48505
Kelly, James E............2765 Flushing Rd., Flint 48504
Kennett, Donald M.................315 Bella Vista Dr., Grand Blanc 48439
Kimbrough, C. B.........1402 S. Saginaw St., Flint 48503
Kitto, Harold J...............902 Stockdale, Flint 48504
Kline, O. F...............2765 Flushing Rd., Flint 48504
Knapp, Wm. D............503 S. Saginaw St., Flint 48502
Knoblich, Roman R..........Hurley Hospital, Flint 48502
Koop, Chester S.....1372 N. Ballenger Hwy., Flint 48504
Kreel, Boris W.......11610 Hazel St., Grand Blanc 48439
Kretchmar, Arthur H. (L)........625 S. Grand Traverse, Flint 48503
Laird, James I..........12010 Kipp Rd., Goodrich 48438
Laurel, Richard J..........1207 N. Ballenger, Flint 48504
La Vielle, Carroll J..........Hurley Hospital, Flint 48502
Leach, J. Leonidas (L)..5014 N. Saginaw St., Flint 48505
Le Mieux, Leslie L........701 W. Dayton St., Flint 48504
Levine, Mark C.........G3083 Flushing Rd., Flint 48504
Lewis, Billie...........739 Mott Fdn. Bldg., Flint 48502
Lewis, Thos. E...........4071 Richfield Rd., Flint 48506
Lewis, Vivian M............1618 Kensington, Flint 48503
Lieber, Robt. W.......6144 Pebbleshire Circ., Flint 48507
Lightfoot, Arthur S..........4500 Detroit St., Flint 48505
Limbach, David R............900 Begole St., Flint 48503
Lindman, Thomas C.........2484 Nolen Dr., Flint 48504
Livesay, Jackson E. (L)...503 S. Saginaw St., Flint 48502
Lundeen, Richard M..............3393 Clio, Flint 48504
Lusk, John A........9233 W. Davison Rd., Davison 48423
Lyttle, Sydney N.....1207 N. Ballenger Hwy., Flint 48504
MacKenzie, J. W...4437 Morrish Rd., Swartz Creek 48473
Macksood, Albert J.......3169 W. Pierson Rd., Flint 48504
Macksood, Jos. A........3169 W. Pierson Rd., Flint 48504
Macksood, William E.....3169 W. Pierson Rd., Flint 48504
MacPhail, Albert A.......3302 Hawthorne Dr., Flint 48503
Mangelsdorf, C. H...........G3393 Clio Rd., Flint 48504
Manwaring, John T........1654 Seminole St., Flint 48503
Markunas, Paul J........4002 N. Saginaw St., Flint 48505
Martin, James A.........812 S. Adelaide St., Fenton 48430
Martins, Helio B. F............714 Beach St., Flint 48502
Mathias, Berton J.........1301 Flushing Rd., Flint 48504
McAlindon, J. D................1601 Euclid, Flint 48503
McClellan, Junius W....Buick Motor Division, Flint 48505
McGarry, Roy A. (L).....601 S. Saginaw St., Flint 48502
McGrae, John D., Jr.......2433 Welch Blvd., Flint 48504
McGregor, Allan R.....G 3337 W. Vienna Rd., Clio 48420
McLeod, Kenneth W. A....2765 Flushing Rd., Flint 48504
McMurray, Richard J......2765 Flushing Rd., Flint 48504
McNaughton, D. W.
McTaggart, David.....625 S. Grand Traverse, Flint 48503
Mendrek, H. H...........2765 Flushing Rd., Flint 48504
Michael, Sidney R.........922 Welch Blvd., Flint 48504
Michels, Robt. M..........2702 Flushing Rd., Flint 48504
Michelson, Richard B...........2014 Robt. T. Longway, Flint 48503
Mikat, Kurt W..........3402 Santa Clara Ct., Flint 48504
Miller, Loren E...........2645 Corunna Rd., Flint 48503
Miltich, Anthony J.....915 S. Grand Traverse, Flint 48503
Moeller, Jan C..........3102 Westwood Pky, Flint 48503
Moore, Glenn E.............323 W. Second, Flint 48503
Moore, Wesley P. (A).....18040 Sorrento, Detroit 48235
Morgan, Alan L.........3169 W. Pierson Rd., Flint 48504
Morin, Paul................1968 Miller Rd., Flint 48503
Morrissey, Vaughn H.......101 Stockdale St., Flint 48503
Mosier, Edward C.........1730 Overhill Dr., Flint 48503
Mueller, Willys F. (M)............Arm. Frc. Inst. Path., Washington, D.C. 20305
Murphy, E. Grant......926 Mott Fdtn. Bldg., Flint 48502
Nassar, S. H..........8483 Holly Rd., Grand Blanc 48439
Newman, Harry S...........302 E. Court St., Flint 48503
Newton, Barabas (A)......McLaren Hospital, Flint 48502
Nicholls, Wm. W..........806 W. Sixth Ave., Flint 48503
Nitz, Donald A.....1818 Robert T. Longway, Flint 48503
Odle, Ira D. (L)...........201 Welch Blvd., Flint 48503
Oldt, Mary Ruth...........602 S. Lynch St., Flint 48503
Orr, John W. (L).....Orrs Pt., Lk. Fenton, Fenton 48430
Pappalardo, Carlos.......1458 Clairwood Dr., Flint 48506
Park, Joon H..........500 S. Grand Traverse, Flint 48503
Parliament, Burt A.........314 Ferndale Pl., Flint 48503
Pfeifer, Archibald C. (L).......9798 Palmetto Club Dr., Miami, Fl. 33157
Phelps, Lynn A........10122 Janaroy Ct., Goodrich 48438
Phillips, A. F......X-ray Dept., Hurley Hosp., Flint 48502
Pickering, Woodrow H...1602 Ballenger Hwy., Flint 48504
Pietruszka, Boleslaw.........5210 Lapeer Rd., Flint 48503
Pike, Wallace W....7514 Miller Rd., Swartz Creek 48473
Platt, Alice Lee (A)......1430 Eldorado Dr., Flint 48504
Portney, Jack E..............725 Stevens St., Flint 48503
Pougnet, W. D..............6155 Maple Ridge, Flint 48504
Pratz, Oliver C. (L).........1303 Detroit St., Flint 48503
Preston, Otto J.........300 N. Chevrolet Ave., Flint 48504
Price, Jack R..........410 S. Ballenger Hwy., Flint 48504
Prior, Richard W..........1266 S. Le Roy, Fenton 48430
Purcell, F. L.................Ternstedt Plant, Flint 48509
Quin, John, Jr.............2765 Flushing Rd., Flint 48504
Rabiah, Fouad........1139 Mott Fdn. Bldg., Flint 48502
Radcenko, Helen........302 W. Pierson Rd., Flint 48505
Radcenko, Leonid........302 W. Pierson Rd., Flint 48505
Rao, D. S. (A)...........McLaren Hospital, Flint 48502
Rapport, Richard L..........503 S. Saginaw, Flint 48502
Rathburn, Robert J........1501 Flushing Rd., Flint 48504
Rawling, John C.........115 Med. Arts. Bldg., Flint 48504
Rawlings, J. Mott..........1601 Neome Dr., Flint 48503
Reid, John H.............1301 Flushing Rd., Flint 48504
Reye, George H...............2279 E. Grand Blanc Rd., Grand Blanc 48439
Rice, Alan K.........2008 Robt. T. Longway, Flint 48503
Rieth, Geo. F..............1406 Davison St., Flint 48506
Roberts, Floyd A. (L)..327 Sheffield, Apt. 281, Flint 48503
Robitaille, M. L...........2765 Flushing Rd., Flint 48504
Rowe, John B...............653 Saginaw St., Flint 48502
Rundles, Walter Z.....500 Grand Traverse St., Flint 48503
Sampaio, Carlos A.......8020 Davison Rd., Davison 48423
Sandberg, Russell G..........2030 Pierce St., Flint 48503
Sanocki, Fredk. E.......915 S. Grand Traverse, Flint 48503
Scavarda, Chas. J...............1106 Maxine, Flint 48503
Schaefer, Richard K.......3248 Van Slyke Rd., Flint 48507
Schafer, Nelson S.....1602 N. Ballenger Hwy., Flint 48504
Schiff, Benton A..............323 W. 2nd St., Flint 48503
Schmidlin, Robt. W.........3710 Davison Rd., Flint 48506
Schreiber, E. Oskar......2765 Flushing Road, Flint 48504
Schroeder, Paul E.........1673 N. Chevrolet, Flint 48504
Schultz, J. Stanley........3327 Fleming Rd., Flint 48504
Schwartz, John M........1300 N. Dort Hwy., Flint 48506
Schwarz, Heinz H............1430 Eldorado, Flint 48504
Seven, Phillip G............2301 Cummings, Flint 48503
Seymour, Geo. D.....G7237 N. Saginaw, Mt. Morris 48458
Shantz, Leighton O. 1497 Country View Lane, Flint 48504
Sheeran, Danl. H.........610 S. Vernon Ave., Flint 48503
Sherwood, Frederick.......2765 Flushing Rd., Flint 48504
Shields, John L........234 W. Caroline St., Fenton 48430
Simoni, Lewis E.........3210 S. Dort Hgwy., Flint 48507
Sirna, Anthony R....11219 Stonybrook, Grand Blanc 48439
Smalley, R. H.....4437 Morrish Rd., Swartz Creek 48473
Smith, Eugene C...............606 Stevens, Flint 48503
Smith, Harold O..............3769 Sunset Dr., Flint 48503
Smith, Maurice J.........2801 N. Saginaw St., Flint 48505
Smith, Sidney E.......625 S. Grand Traverse, Flint 48503
Sniderman, Benj. F............727 Beach St., Flint 48502
Solik, A. E..................311 E. Court St., Flint 48503
Somach, Fredric M.........2765 Flushing Rd., Flint 48504
Sorkin, Morris L...............718 Beach St., Flint 48502
Sorkin, Saml. S................718 Beach St., Flint 48502
Sorscher, Alan J. (A).....Keesler AFB, Biloxi, Ms. 39534
Southall, Warren E.........4250 N. Saginaw, Flint 48505
Sparks, Harvey V.........2765 Flushing Rd., Flint 48504
Steffe, Ralph S...........2765 Flushing Rd., Flint 48504
Steinman, Floyd H.......503 S. Saginaw St., Flint 48502
Stevens, Philip K......1116 Mott Fdtn. Bldg., Flint 48502
Stevenson, Wm. W. (L)....1521 Arrow Lane, Flint 48507
Streat, Rudolph W. (L).......218 E. 8th St., Flint 48503
Stroup, Clayton K.........2002 E. Court St., Flint 48503
Sullivan, M. R....5352 Peppermill Rd., Grand Blanc 48439
Sutherland, James K............402 E. 3rd St., Flint 48503
Sutton, Geo. D. (L).......303 W. Court St., Flint 48503
Tang, Gene D.........926 Mott Fdtn. Bldg., Flint 48502
Tauscher, John W...2016 R. T. Longway Blvd., Flint 48503
Theuerle, Walter I.......3101 N. Saginaw St., Flint 48505
Thompson, Charles A.....4211 Comstock St., Flint 48504
Thompson, Jack W........2702 Flushing Rd., Flint 48504

Thoms, Peter S.......1279 W. Coldwater Rd., Flint 48505
Tofteland, Elmer H.......2765 Flushing Rd., Flint 48504
Tower, Rita B. (L).............Elms Trailer Park, D4,
2801 S. Dort Hwy., Flint 48507
Turcke, Allen F............1245 Dupont St., Flint 48504
Turner, Merald G.........G 3169 W. Pierson, Flint 48504
Tuuri, Arthur L.........Mott Children Clinic, Flint 48502
Urich, Vernon..........3169 W. Pierson Rd., Flint 48504
VanBrocklin, J. D.........2765 Flushing Rd., Flint 48504
Van Duyne, Fredk. W.......2849 Miller Rd., Flint 48503
Van Harn, Raymond S.....1116 Ann Arbor St., Flint 48503
Varjavandi, Siavosh.....3169 W. Pierson Rd., Flint 49504
Varney, Howard L. 1818 Robt. Longway Blvd., Flint 48503
Vaughan, Edgar J.........319 S. Bridge St., Linden 48451
Velarde, Nicholas N.......3083 Flushing Rd., Flint 48504
Villarreal, Virgilio............3917 Kellar St., Flint 48504
Wade, Franklin V.....1121 Mott Fdtn. Bldg., Flint 48502
Walcott, Carver G......201 E. Caroline St., Fenton 48430
Walker, James D. 11325 S. Saginaw St., Grand Blanc 48439
Walter, Daniel L.........820 Davison Rd., Davison 48423
Ward, Nell M. (L).....G4152 Carnation Ct., Flint 48506
Weber, Richard E.....420 S. Ballenger Hwy., Flint 48504
Weber, Robt. M...........3710 Davison Rd., Flint 48506
Wentworth, John E..........420 S. Ballenger, Flint 48504
Werness, Inga W. (L)...220 East Fourth St., Flint 48503
West, George A.........6518 N. Saginaw St., Flint 48505
Wheeler, J. D..........926 Mott Fdtn. Bldg., Flint 48502
White, Carl H..............106 River St., Fenton 48430
White, Frank T............5210 Lapeer Rd., Flint 48503
Whites, Jack C.........7343 Flushing Rd., Flushing 48433
Willard, Robt. H..............718 Beach St., Flint 48502
Williams, Wm. S. (L) 5216 S. Genesee, Grand Blanc 48439
Willis, Robert E..........6606 N. Saginaw St., Flint 48505
Wills, Thos. N. (R)..Chicaugdan Lake, Crystal Falls 49920
Wolcott, Nan D. (R)....7506 Lapeer Rd., Davison 48423
Wolf, Melvyn D........G 3083 Flushing Rd., Flint 48503
Woodsides, K. T.......7343 Flushing Rd., Flushing 48433
Wright, Donald R. (L)....326 W. Court St., Flint 48503
Wright, Geo. W., Jr. 2279 Grand Blanc, Grand Blanc 48439
Zeis, Myron G................718 Beach St., Flint 48502
Zelko, Daniel M...........4071 Richfield Rd., Flint 48506

GOGEBIC COUNTY MEDICAL SOCIETY (66)

Albert, Saml. G..........103 Suffolk St., Ironwood 49938
Davidson, Donald L.....200 S. Sophie St., Bessemer 49911
Franck, John R., Jr.....401 Sunday Lake, Wakefield 49968
Gallo, Bela.............Newport Clinic, Ironwood 49938
Gertz, Michael A......109 E. Aurora St., Ironwood 49938
Gorrilla, Allen C..........210 Suffolk St., Ironwood 49938
Harrington, Rex R., Jr...104 E. Ridge St., Ironwood 49938
Lieberthal, M. J. (L)..220 S. Suffolk St., Ironwood 49938
Lieberthal, Paul R. (L)........Box 632, Ironwood 49938
Medford, Lester....306 Sunday Lake St., Wakefield 49968
Murphy, Percy J.......121 Calumet Ave., Calumet 49913
Santini, Florian J.......109 E. Aurora St., Ironwood 49938

GRAND TRAVERSE-LEELANAU-BENZIE COUNTY MEDICAL SOCIETY (70)

Barstow, Richard G.....3630 Garfield, Traverse City 49684
Bartone, John R.....217 S. Madison, Traverse City 49684
Beall, John G......1105 E. Front St., Traverse City 49684
Berens, Burdette M.....................Kalkaska 49646
Blount, Harry M...434 N. Monroe St., Traverse City 49684
Bolan, Ellis J................Box 67, Suttons Bay 49682
Brownson, Kneale M.....116 Cass St., Traverse City 49684
Bushong, Benj. B.......116 Cass St., Traverse City 49684
Campbell, Thomas D.........Box C, Traverse City 49684
Cartwright, Wm. H. 1105 E. Front St., Traverse City 49684
Clark, Oswald V.......1030 Sixth St., Traverse City 49684
Cline, Theodore N...........999 6th, Traverse City 49684
Cline, Warren W............999 6th, Traverse City 49684
Coleman, John F......1100 Sixth St., Traverse City 49684
Dundon, Arthur F.....1100 Sixth St., Traverse City 49684
Edmonds, W. T.......Munson Hosp., Traverse City 49684
Ellis, Claude I.......................Suttons Bay 49682
Ferguson, John T.............Box C, Traverse City 49684
Fiebing, Jack A........P.O. Box 283, Traverse City 49684
Fishbeck, Wm. A.....1209 E. 8th St., Traverse City 49684
Fox, Richard L.......207 Circle Dr., Traverse City 49684
Fulmer, Roger C...9838 Peninsula Dr., Traverse City 49884
Goodrich, Dwight (R)................601 W. Front St.,
Traverse City 49684
Haberlein, Chas. R.....1100 Sixth St., Traverse City 49684
Hall, James W.........1100 Sixth St., Traverse City 49684
Hall, Thomas C.......1100 Sixth St., Traverse City 49684
Hamilton, Earl E....530 S. Union St., Traverse City 49684
Harwood, Jerold R.....1100 Sixth St., Traverse City 49684
Herkner, Mildred L..............Traverse City St. Hosp.,
Traverse City 49684
Hubbell, Reader J....228 S. Madison, Traverse City 49684
Huene, Nevin......110 E. Front St., Traverse City 49684
Huston, R. R. (L)...................Elk Rapids 49629
Johnson, Robert C......116 Cass St., Traverse City 49684
Johnston, James D.....1100 Sixth St., Traverse City 49684
Kamp, Robt. L..........................Beulah 49617
Kaufman, James N........427½ Main St., Frankfort 49635
Kitti, Wm. W.........................Kalkaska 49646
Komesu, Seiichi.............Box C, Traverse City 49684
Larson, Conrad E...............Munson Medical Center,
Traverse City 49684
Lemen, Charles E.....110 S. Madison, Traverse City 49684
Lian, Teck S...........518 Eleanor Ave., Saginaw 48602
Lieding, Keith G...7844 Peninsula Dr., Traverse City 49684
Lossman, Robt. T..............J. Decker Munson Hosp.,
Traverse City 49684
McClay, Adam C.......6330 Pen Dr., Traverse City 49684
Michael, Stanley L.....335 Davis St., Traverse City 49684
Milliken, John G......224 Circle Dr., Traverse City 49684
Mueller, Karl A. (A)...721 Sixth St., Traverse City 49684
Nickels, Mervyn M...........Box C, Traverse City 49684
Novack, Richard L.........408 Main St., Frankfort 49635
Paterson, Roger..........204 W. State, Mancelona 49659
Pearson, Robt. E. (A)..............611 Birchwood Ave.,
Traverse City 49684
Pelto, Maurice S....Munson Hospital, Traverse City 49684
Peterson, Wm. D....876 E. Front St., Traverse City 49684
Pike, Donald G.....1105 E. Front St., Traverse City 49684
Ponczek, E. J...Box C, State Hospital, Traverse City 49684
Power, Frank H...........116 Cass St., Traverse City 49684
Salon, Dayton D........1030 6th St., Traverse City 49684
Scheidler, Edw. P., Jr...............10610 Peninsula Dr.,
Traverse City 49684
Schroeder, Dwight M..................Northport 49670
Skendzel, L. P.....Munson Hospital, Traverse City 49684
Sladek, Edward F. (L)................123 E. Front St.,
Traverse City 49684
Sommerness, M. Duane.......Box C, Traverse City 49684
Sorum, F. T.................Box C, Traverse City 49684
Spencer, John R....1124 E. Front St., Traverse City 49684
Steffey, Jos. C.......116 Cass Street, Traverse City 49684
Stokes, G. Edward....1100 Sixth St., Traverse City 49684
Swartz, Fred G. (L)....612 Sixth St., Traverse City 49684
Sweeney, Bernard J....1100 Sixth St., Traverse City 49684
Thacker, Fredk. R.............Front St., Frankfort 49635
Thirlby, Richard L...228 S. Madison, Traverse City 49684
Wagener, Creighton A. 1100 Sixth St., Traverse City 49684
Weih, Jack E......1105 E. Front St., Traverse City 49684
Weitz, Harry L.......Munson Hosp., Traverse City 49684
Wilcox, Paul H........333 Sixth St., Traverse City 49684
Wiley, Philip K.........116 Cass St., Traverse City 49684
Williams, Chas. R......416 Sixth St., Traverse City 49684
Willoughby, Gordon W......104 5th St., Frankfort 49635
Wolfgram, Lavern V.....1209 E. 8th, Traverse City 49684
Wonacott, Robert G.....107 Dexter St., Elk Rapids 49629
Wright, J. K., Jr....1105 E. Front St., Traverse City 49684
Wunsch, Richard E..................1122 E. Front St.,
Traverse City 49684
Young, John Harley..Children's Clinic, Traverse City 49684
Zielke, Irwin H......106 S. Madison, Traverse City 49684
Zimmerman, Jos. G...102 W. Front St., Traverse City 49684

GRATIOT-ISABELLA-CLARE COUNTY MEDICAL SOCIETY (74)

Aldrich, Alfred L.........................Ithaca 48847
Baker, Jerald F......906 S. Kinney St., Mt. Pleasant 48858
Barstow, Donald K.....................Engadine 49827
Bauer, A. Robert, Jr...412 E. Broadway, Mt. Pleasant 48858
Baybura, Orhan..........503 E. Main St., Edmore 48829
Becker, Myron G.........................Edmore 48829
Bedo, Andrew V.......802 Gordon, Mount Pleasant 48858
Bergin, Jos. H..............112 E. Superior, Alma 48801
Brenner, E. J. (R)..........Central Mich. Comm. Hosp.,
Mt. Pleasant 48858
Budge, Melvin J. (L)......1002 Folkirk St., Alma 48801
Burt, Loren G..............510 Prospect St., Alma 48801
Chamberlain, Ray W..................608 E. Chippewa,
Mount Pleasant 48858
Chamichian, Souren L......Canal Rd., Mt. Pleasant 48858
Davis, Lionel L...314 S. Brown St., Mount Pleasant 48858
Dunlop, Donald........301 East Fourth St., Clare 48617
Fishbaugh, Wm. F., Jr.......936 W. Center, Alma 48801
Graham, Bernard J........510 Prospect Ave., Alma 48801
Haddad, T. E.....207 N. Franklin St., Mt. Pleasant 48858
Hammerberg, Kuno...........622 McEwan, Clare 48617
Harrigan, Wm. L...90th at School Section, Mecosta 49332
Hedges, Frank W.......215 W. Saginaw, St. Louis 48880
Hersee, Wm. E.....306 S. College, Mount Pleasant 48858
Hobbs, A. Deane (R)..Box 3233, Florence Vill., A Station,
Winter Haven, Fl. 33880
Johnson, Frank D.....806 E. Bellows, Mt. Pleasant 48858
Johnson, Philip R..................206 S. College Ave.,
Mount Pleasant 48858
Johnson, Robert B.....................R. 1, Ithaca 48847
Juhnke, Le Roy W...................314 S. Brown St.,
Mount Pleasant 48858
Klauer, James D...Community Hospital, Mt. Pleasant48858
Lusis, Alexsandrs................St. Home & Tr. School,
Mt. Pleasant 48858
McArthur, Stewart C..............Box 32, Rosebush 48878
Meyer, Edwin G...........................Alma 48801
Minster, John J......314 S. Brown St., Mt. Pleasant 48858
Nagler, Donald F...........Route 3, Mt. Pleasant 48858
Nosan, Martin M....1332 North Drive, Mt. Pleasant 48858
Ragan, Russell M...1715 East High St., Mt. Pleasant 48858
Rank, Robert K................Central Comm. Hospital,
Mt. Pleasant 48858
Roth, Wm. J...............303 W. Superior, Alma 48801
Rottschaefer, John L.....3580 Northlawn Pk., Alma 48801
Rutt, Wilmer M..........310 Warwick Dr., Alma 48801
Sanders, Jack F.......Mich. Masonic Home, Alma 48801
Scott, Lincoln B., Jr.............R. 3, Mt. Pleasant 48858
Silvert, Pasche P.......................Vestaburg 48891
Smith, Dennis V. (L)............Box 252, Farwell 48622
Soriano, D. A........218 W. High St., Mt. Pleasant 48858
Stack, Jack M.............310 Warwick Rd., Alma 48801
Veldhuis, Andrew H...801 Gordon Rd., Mt. Pleasant 48858
Waggoner, Richard L...712 Michigan Ave., St. Louis 48880
Wallman, C. Harry............901 State St., Alma 48801
Wickert, Leo R.....1001 Watson Rd., Mt. Pleasant 48858
Wilcox, Rex A.................525 State St., Alma 48801
Wilson, Earl C.........................Harrison 48625
Wolfe, Kenneth P.........510 Prospect Ave., Alma 48801
Wood, Cornelius B...........Route 2, Mt. Pleasant 48858
Wood, John M....1300 S. Watson Rd., Mt. Pleasant 48858

HILLSDALE COUNTY MEDICAL SOCIETY (78)

Bates, Morton P...............Olin Hlth. Center, MSU,
East Lansing 48823
Davis, William B. ....55 Barry, Hillsdale 49242
Day, Luther W. (A).............Grosvener Bnk. Bldg.,
Jonesville 49250
Gates, Jon H. (M).................67th Tuslog Det,
APO 09380, N.Y.
Henelt, Edmond............32 S. Broad, Hillsdale 49242
Hodge, Chas. L.........................Reading 49274
MacNeal, John A...........379 S. Broad, Hillsdale 49242
Mattson, H. Frazyer......32 S. Broad St., Hillsdale 49242
Peterson, Carl A..............59 Barry St., Hillsdale 49242
Powers, Ward O.......................Jonesville 49250
Reigle, Frederick C....................Litchfield 49252
Sawyer, Walter W.......61 N. Howell St., Hillsdale 49242
Smith, Clark B............252 S. Howell, Hillsdale 49242
Stein, Arthur J...........144 Budlong St., Hillsdale 49242
Strom, Arthur W.........32 S. Broad St., Hillsdale 49242
Tarr, John...........................Camden 49232
Trapp, Donald G.........32 S. Broad St., Hillsdale 49242
Wiggins, Ira W.....Box 5007, Cristobal, Canal Zone

HOUGHTON-BARAGA-KEWEENAW COUNTY MEDICAL SOCIETY (82)

Aldrich, Addison B.......325 Harris Ave., Hancock 49930
Aldrich, Leonard C.......301 Quincy St., Hancock 49930
Barrios, Honorato.........424 Quincy St., Hancock 49930
Conner, William T.......146 Osceola St., Laurium 49913
Goodreau, Paul G.........301 Quincy St., Hancock 49930
Hillmer, Raymond E. (L)...............Painsdale 49955
Janis, Anton J............208 Quincy St., Hancock 49930
Kolb, Fredk. E........128 Calumet Ave., Calumet 49913
La Bine, Alfred (L)......Masonic Bldg., Houghton 49931
La Core, Ivan A...Rice Memorial Clinic, Houghton 49931
Lanczy, Tamas O...Baraga County Hospital, L'Anse 49946
Larson, Forrest W..........322 Shelden, Houghton 49931
Lepisto, Victor E.........210 Quincy St., Hancock 49930
Meier, Maurice D.........1033 Mine St., Calumet 49913
Parker, Thomas M. (M).............U. S. Naval Hosp.,
Portsmouth, Va. 23708
Repola, Kenneth L. 400 Maynard St. 704, Ann Arbor 48108
Roche, Andrew M..........221 5th St., Calumet 49913
Rowe, Kenneth E.....107½ Calumet Ave., Calumet 49913
Rowell, Wilfred J. (R)..............Eagle Harbor 49951
Sandell, Samuel T........305 Vivian St., Houghton 49931
Sloan, Paul S.........609 Sheldon Ave., Houghton 49931
Stroube, John A............522 W. Third, L'Anse 49946
Williams, Marshall S...St. Joseph's Hospital, Hancock 49930
Winkler, Henry J................Box 461, L'Anse 49946

HURON COUNTY MEDICAL SOCIETY (86)

Brouillette, J. N...........106 Willis St., Bad Axe 48413
Dixon, Ralph C..................Box 77, Pigeon 48755
Elliott, Chas. S.........................Pigeon 48755
Ellis, Larry G........693 S. Bay Port Rd., Bay Port 48720
Herrington, C. Clark..117 S. Port Crescent, Bad Axe. 48413
Herrington, K. B.......317 Port Crescent, Bad Axe 48413
Jones, David L........206 Heisterman St., Bad Axe 48413
Kube, Kenneth S.......................Bad Axe 48413
Mullaney, J. M., Jr...108 S. Port Crescent, Bad Axe 48413
Oakes, Chas. W., Jr................Harbor Beach 48441
Oakes, Robert W.................7890 Sand Beach Rd.,
Harbor Beach 48441
Scheurer, Clare A........................Pigeon 48755
Sidagis, Joseph..........6 W. Main St., Sebewaing 48759
Sorensen, Maurice G.............P. O. Box, Elkton 48731
Steinhardt, Edward E..............Box 15, Elkton 48731
Turner, Phillip R.....230 S. First St., Harbor Beach 48441
Wible, Chas. F., Jr...................Sebewaing 48759
Willits, Robert A...........193 N. Main St., Elkton 48731

INGHAM COUNTY MEDICAL SOCIETY (90)

Adams, Charles......2909 E. Grand River, Lansing 48912
Agate, Geo. H......Mich. Dept. of Hlth., Lansing 48906
Aiken, Donald J...Grandview & Grand Rv., Okemos 48864
Alexander, Reuben G.....701 N. Logan St., Lansing 48914
Allis, Harry D.......2909 E. Grand River, Lansing 48912
Altland, J. K...........Route 2, Box 178, Lansing 48917
Asselin, David C.......1322 E. Michigan, Lansing 48912
Badgley, Waldo O.....930 N. Washington, Lansing 48906
Baker, Thos. C.........930 N. Washington, Lansing 48906
Bassett, Robt. C...1322 E. Michigan Ave., Lansing 48912
Bates, Richard.......2909 E. Grand River, Lansing 48912
Bauer, Theodore I (L)..........810 Mich. Nat. Tower, Lansing 48933
Beaubien, Mark S. (A)............1006 Wildwood Dr., East Lansing 48823
Behen, Wm. C. (L)..535 S. Capitol Ave., Lansing 48933
Behney, Charles A. (L)..........Box 4256 San Jose Dr., Bisbee, Az. 85603
Bellinger, Ernest G. (L)......Masonic Home, Alma 48801
Berden, Eleanor A......2630 Libbie Drive, Lansing 48917
Bergeon, Milton C...1021 W. Dansville Rd., Mason 48854
Bethards, Rolland E.....Sparrow Hospital, Lansing 48902
Bevez, Frank L....3209 S. Cambridge Rd., Lansing 48910
Bingham, B. Wayne......1034 E. Saginaw, Lansing 48906
Black, Chas. E...........112 W. Allegan, Lansing 48933
Blaek, Gertrude C. K.............529 W. Grand River, Williamston 48895
Blair, Thomas C....1322 E. Michigan Ave., Lansing 48912
Bleil, Eugene E....1322 E. Michigan Ave., Lansing 48912
Bradford, Carl W.....832 Westlawn, East Lansing 48823
Briggs, James......................Box 68, Holt 48842
Brown, Fredk. W., Jr...........831 N. Washington Ave., Lansing 48906
Brown, Joseph C....................Box 68, Holt 48842
Brubaker, Earl W. (L).........103 N. Washington Ave., Lansing 48933
Budden, M. Arthur..2909 E. Grand River, Lansing 48912
Burge, Terry E.....................Box 68, Holt 48842
Byerrum, Mr. Richard U. (A)........602 Wildwood Dr., East Lansing 48823
Cairns, Donald A...........136 W. Ash St., Mason 48854
Calomeni, Anthony D...1850 W. Mt. Hope, Lansing 48910
Carlson, Ralph G.........225 S. Waverly, Lansing 48917
Carr, Earl I. (L)..1915 Moores River Dr., Lansing 48910
Caruso, Joseph A........701 N. Logan St., Lansing 48915
Casey, Byron L........202 M. A. C., East Lansing 48823
Chaskes, Marian I. G...210 E. Hillsdale St., Lansing 48933
Chemycz, Joseph R....4930 Hillcrest Ave., Okemos 48864
Cheney, Wm. D.....Sparrow Hosp. X-ray, Lansing 48902
Chi, Seong H. (A)..Ingham Medical Hosp., Lansing 48910
Cipparone, Joseph R...St. Lawrence Hosp., Lansing 48914
Clark, Gaius D...1829 Ridgewood Dr., East Lansing 48823
Clark, Melvin (A)..4558 Marlborough Rd., Okemos 48864
Clark, Wm. E..............131 E. Oak St., Mason 48854
Clinton, Geo. R.....................R. 2, Mason 48854
Clore, Forrest C. (M)
Collier, Beverly A......2210 Montego Dr., Lansing 48912
Collier, Richard L......2210 Montego Dr., Lansing 48912
Combs, Robert G...1023 E. Michigan Ave., Lansing 48912
Comstock, Howard C. 2909 E. Grand River, Lansing 48912
Cope, Henry E. (R)...605 Westmoreland, Lansing 48915
Cordes, Jerome F.....2909 E. Grand River, Lansing 48912
Corneliuson, G. B. (R)..Ellis Rd., Drummond Island 49726
Cowan, John A.........825 Touraine, East Lansing 48823
Crow, Harold E. 2909 E. Grand River Ave., Lansing 48912
Dale, Edward C..................Health Service, MSU, East Lansing 48823
Daugherty, Robert M.............599 Pebblebrook Lane, East Lansing 48823
Davis, Don G...........701 N. Logan St., Lansing 48915
Dawe, C. D......1515 W. Mt. Hope Ave., Lansing 48910
De Vries, Corydon F. (L)... ....320 Townsend St., Lansing 48933
Dexter, M. J................229 E. Maple, Mason 48854
Dorner, Kenneth R...2909 E. Grand River, Lansing 48912
Drolett, Alfred J. (L)..1018 Prudden Bldg., Lansing 48933
Drolett, Donald J...1322 E. Michigan Ave., Lansing 48912
Drolett, Lawrence A.....1036 Morris Ave., Lansing 48917
Dunkel, John F...Edw. W. Sparrow Hosp., Lansing 48902
Dunn, Forest M....1322 E. Michigan Ave., Lansing 4891
Ellis, Bertha W. (R)....................P. O. Box 2327 Hollywood, Fl. 3302
Ellis, C. Ward (L)..P. O. Box 2327, Hollywood, Fl. 3302
Ellison, Alfred, Jr..............2909 E. Grand River 202 Lansing 4891
Feeney, Kenneth J. 1908 Mich. Natl. Tower, Lansing 4893
Feurig, James S.......321 Kensington, East Lansing 4882
Flory, Clyde R., Jr......201 W. Hillsdale, Lansing 4893
Folkers, Leonard M.................234 Michigan Ave. East Lansing 4882
Forbes, John D....Oldsmobile Div., GMC, Lansing 4893
Fortino, Silvio P.....2909 E. Grand River, Lansing 4891
Fryer, Douglas H....Mich. Dept. of Hlth., Lansing 4890
Garlinghouse, A. John., Jr.........1322 E. Michigan Ave. Lansing 4891
Gellar, Abraham........108 Division, East Lansing 4882
George, Harry C.........335 Seymour St., Lansing 4893
Ghannam, Rasem....2909 E. Grand River, Lansing 4891
Ginnebaugh, L. A. (A)....1915 Fordney, Saginaw 4860
Goldner, Roy E...1318 S. Washington Ave., Lansing 4891
Govons, Sidney R...1322 E. Michigan Ave., Lansing 4891
Grey, Anna B. (L)....915 Cajon St., Redlands, Ca. 9237
Hames, R. E.......1322 E. Michigan Ave., Lansing 4891
Hanna, Roger J............117 E. Maple St., Mason 4885
Harrington, Louis E...3526 W. Saginaw St., Lansing 4891
Harris, Herbert W........919 Chester Rd., Lansing 4891
Harrison, Wm. H....834 W. St. Joseph St., Lansing 4891
Harrold, Jesse F............326 W. Ionia, Lansing 4893
Hatton, R. L.........4462 Greenwood St., Okemos 4886
Hay, Kent R.......1322 E. Michigan Ave., Lansing 4891
Hayes, Robt. E.....1322 E. Michigan Ave., Lansing 4891
Hayford, Wm. D.....1028 E. Saginaw St., Lansing 4890
Heald, Gordon H...714 Abbott Road, East Lansing 4882
Heekert, Frank B. 1105 Bnk. of Lnsg. Bldg., Lansing 4893
Heckert, Jos. K. (L)..........1105 Bnk. of Lnsg. Bldg. Lansing 4893
Heerdt, Mark E..........810 W. Saginaw, Lansing 4891
Henderson, Norman D.................726 Lansing Rd. East Lansing 4882
Heustis, Albert E. 1111 Michigan Ave., East Lansing 4882
Hill, Thos. B.........554 Durand St., East Lansing 4882
Himmelberger, R. J.......3624 Colchester, Lansing 4890
Hiseoe, D. Bonta....2909 E. Grand River, Lansing 4891
Hoehglaube, Jaeque............701 N. Logan, Suite 515 Lansing 4891
Hoffer, W. E. (L).....331 Shepard Street, Lansing 4891
Hogg, Raymond E....2909 E. Grand River, Lansing 4891
Holland, Chas. F.........810 W. Saginaw, Lansing 4891
Horvath, Francis..MSU Health Center, East Lansing 4882
Howie, Charles (M)..1546 B Cedar, Fort Dix, N.J. 0864
Hoyt, John C.......................Box 66, Holt 4884
Huggett, Clare C...122 W. Gd. River Ave., Lansing 4890
Hunt, Andrew D., Jr.........Coll. of Human Med., MSU East Lansing 4882
Hurth, M. S.............1717 Jerome St., Lansing 4891
Isbister, J. L.....Dept. Health, DeWitt Rd., Lansing 4890
Iung, Omero S................411 Bartlett, Lansing 4891
Jacob, S. Sprigg, III.....201 Ann St., East Lansing 4882
Jarstfer, Bruce S.. (M)........USA, Tripler Gen. Hosp. Honolulu, Hawaii 9681
Johnson, David B.....2909 E. Grand River, Lansing 4891
Johnson, Kenneth H. (L)........1116 Mich. Nat. Tower Lansing 4893
Johnson, Lanny L. 903 E. Grand River, East Lansing 4882
Johnson, Richard..2909 E. Grand River 202, Lansing 4891
Jones, Francis A., Jr. (R)...........815 Royal Palm Pl. Vero Beach, Fl. 3296
Jones, Lester C...2909 E. Grand River 203, Lansing 4891
Jones, Martin F......2909 E. Grand River, Lansing 4891
June, Robt. C.............209 W. Walnut, Lansing 4893
Kahn, David........2909 E. Grand River, Lansing 4891
Kalmbach, Roland E. (L)........1322 E. Michigan Ave. Lansing 4891
Kasilag, Filomeno B....401 W. Greenlawn, Lansing 4891
Katlein, Stanley............2231 Heritage, Okemos 4886
Kellerman, Howard H............1322 E. Michigan Ave. Lansing 4891
Kelly, William................Cass Bldg., Lansing 4891

ent, A. Edith Hall............Box 1167, Lansing 48904
ent, Herbert K...............Box 1167, Lansing 48904
enyon, Fanny H. (L)..624 LaSalle Blvd., Lansing 48912
inzel, Raymond C.........326 W. Ionia St., Lansing 48933
lunzinger, W. R........326 W. Ionia St., Lansing 48933
nisley, Wm. H. (A)..............731 Oakwood Drive, East Lansing 48823
ovich, Eleanore..MSU Health Center, East Lansing 48823
ozak, Jerome S.........919 Chester Rd., Lansing 48912
raft, Lester C.............209 S. Main St., Leslie 49251
andick, Robt. E., Jr.....810 W. Saginaw, Lansing 48915
ange, Philip F......2025 W. Holmes Rd., Lansing 48910
anting, Helen E. P.....600 Lesher Place, Lansing 48912
arkey, Paul E.......110 N. Rosemary St., Lansing 48917
arson, Homer I....1322 E. Michigan Ave., Lansing 48912
auzun, Virginia D................1654 E. Grand River, East Lansing 48823
e Duc, Don M....1322 E. Michigan Ave., Lansing 48912
eshock, Jos. C.........701 N. Logan St., Lansing 48915
evett, Harry L. 2909 E. Grand River Ave., Lansing 48912
ewis, Clayton, Jr....2909 E. Grand River, Lansing 48912
innell, Paul C.............701 N. Logan, Lansing 48915
linas, Jose J.......Ingham Med. Hospital, Lansing 48910
ong, Chas. O., Jr....2909 E. Grand River, Lansing 48912
oree, Maurice C.....120 W. Hillsdale St., Lansing 48933
oughrin, T. D......1005 Abbott Rd., East Lansing 48823
ovoll, Kaare............209 N. Walnut, Lansing 48933
ucas, Thos. A........1515 W. Mt. Hope, Lansing 48910
udlum, Lewis C.....1126 W. Saginaw St., Lansing 48915
Ialcolm, Henry E...1005 Abbott Rd., East Lansing 48823
Ialdonado, W. E........Sparrow Hospital, Lansing 48902
Iannausa, L. R.....1005 Abbott Rd., East Lansing 48823
Iartin, Wayne O........4765 Nakoma Dr., Okemos 48864
Iarzolf, M. Finette (N)..........3315 Wisconsin N.W., Washington, D.C. 20016
Iavromatis, E.....1322 E. Michigan Ave., Lansing 48912
Iavromatis, F.....1322 E. Michigan Ave., Lansing 48912
Iay, Stephen G. 202 M. A. C. Avenue, East Lansing 48823
IcCorvie, C. Ray (L)..........525 N.E. Hayworth Rd., Port Charlotte, Fl. 33950
IcCorvie, Donald R.............Williamston Med. Bldg., Williamston 48895
IcElmurry, Leland R...209 N. Walnut St., Lansing 48933
IcFarlane, Donald R............1322 E. Michigan Ave., Lansing 48912
IcGillicuddy, O. B. (L)........1816 Mich. Natl. Tower, Lansing 48933
IcKenney, Marvin J.............1322 E. Michigan Ave., Lansing 48912
Ieade, Wm. H.........1023 E. Michigan, Lansing 48912
Ieinke, Richard K. 1322 E. Michigan Ave., Lansing 48912
Ielick, Richard C...........326 W. Ionia, Lansing 48933
Iercer, Walter E. (R) 909 Glenhaven, East Lansing 48823
Iessenger, A. L....1322 E. Michigan Ave., Lansing 48912
Iiller, J. T., Jr. (M)...............USNR MOQ 3054, Camp LeJeune, N. C. 28542
Iiller, Willard J.......930 N. Washington, Lansing 48906
Iirkil, V. Jerome.....1740 Foxcroft, East Lansing 48823
Ionfort, Robt. N. (R)..300 Pacific Rd., Miami, Fl. 33149
Ioore, Charles R...1322 E. Michigan Ave., Lansing 48912
Ioore, Donald B...1322 E. Michigan Ave., Lansing 48912
Iorrow, Robt. J. (R)....3117 Revere Pl., Lansing 48910
Vakfoor, Eugene C......701 N. Logan St., Lansing 48915
Veering, James C...1322 E. Michigan Ave., Lansing 48912
Veuman, John R...3911 W. Michigan Ave., Lansing 48917
Vewitt, A. W. (L) 1616 W. Michigan Ave., Lansing 48915
Vicholas, Mildred V. 5596 Portage Lake Rd., Dexter 48130
Viland, Paul T.....1322 E. Michigan Ave., Lansing 48912
)chsner, Paul J.........Fisher Body Corp., Lansing 48915
)jeda, Pedro....1515 W. Mt. Hope Ave., Lansing 48910
acker, John H......2909 E. Grand River, Lansing 48912
'aine, Wm. G........1028 E. Saginaw St., Lansing 48906
'almer, R. E. (L).................1627 Wildwood Rd., Clearwater, Fl. 33516
'arker, Earl E.............207 E. Bellevue, Leslie 49251
'ayne, Thomas C............2909 E. Grand River Ave., Lansing 48912
'eets, Ronald.....Gr. River & Grandview, Okemos 48864
'erry, Robert A............701 N. Logan, Lansing 48915

Philips, David P. (R)..1217 Loraine Ave., Lansing 48910
Plant, John F........2909 E. Grand River, Lansing 48912
Plesscher, Wm. H...1322 E. Michigan Ave., Lansing 48912
Pomeroy, Richard W.......Sparrow Hosp., Lansing 48912
Powell, Gerald D.......1850 W. Mt. Hope, Lansing 48910
Pung, Elba Molina..............Olin Health Ctr., MSU, East Lansing 48823
Quigley, Donald R.......701 N. Logan St., Lansing 48915
Reizen, Maurice S...119 W. Washtenaw St., Lansing 48904
Reynolds, Edward E.....Rt. 2, Box 1B, Williamston 48895
Rice, R. G............252 Hollister Bldg., Lansing 48933
Richards, Frank D...1322 E. Michigan Ave., Lansing 48912
Richardson, M. L. (L)....410 Albert, East Lansing 48823
Ringer, Edward L.......122 W. Hillsdale, Lansing 48933
Robinson, Thomas H.........P.O. Box 204, Lansing 48901
Robson, Edmund J.....215 N. Walnut St., Lansing 48933
Rollstin, Robt. A.......1014 Townsend St., Lansing 48933
Ruhmkorff, Ralph H................MSU Health Center, East Lansing 48823
Rutledge, Saml. H., Jr...........1322 E. Michigan Ave., Lansing 48912
Saenz, Hugo R........1515 W. Mt. Hope, Lansing 48910
Saker, James H.......201 W. Hillsdale St., Lansing 48933
Sander, John F.........4780 Okemos Rd., Okemos 48864
Scallin, J. F.............810 W. Saginaw, Lansing 48915
Schaffer, Carole S. (A)..............846 Audubon Rd., East Lansing 48823
Scharphorn, James..1418 Vine St., Apt. 13, Lansing 48912
Scheidt, R. Rudolph.....201 W. Hillsdale, Lansing 48933
Schmidt, Harry J.....2909 E. Grand River, Lansing 48912
Schultz, Arthur E........4646 Ottawa Dr., Okemos 48864
Seger, Fred L. (L)...............1035 Cherry St. N.E., St. Petersburg, Fl. 33701
Shapiro, Hyman D...1327 E. Michigan Ave., Lansing 48912
Sharp, Mahlon S...........521 N. Capitol, Lansing 48933
Shaw, Milton..........320 Townsend St., Lansing 48933
Sheets, Joseph L......521 N. Capitol Ave., Lansing 48933
Sherman, Geo. A. (L)...112 W. Hillsdale, Lansing 48933
Sichler, Harper G. (R)............1476 Stonegate Lane, East Lansing 48823
Siegel, David........2909 E. Grand River, Lansing 48912
Silverman, Irving E...2909 E. Grand River, Lansing 48912
Sleight, Justin L......2909 E. Grand River, Lansing 48912
Smith, Anthony V........116 W. Sycamore, Mason 48854
Smith, Roy............121 Beech St., East Lansing 48823
Smookler, Bernard H. 2909 E. Grand River, Lansing 48912
Snyder, Le Moyne (R)....P.O. Box S, Paradise, Ca. 95969
Snyder, Ruth C. E...............234 W. Michigan Ave., East Lansing 48823
Spagnuolo, Alfred J.....1418 S. Logan St., Lansing 48910
Spencer, J. Clyde........Sparrow Hospital, Lansing 48902
Spencer, Perry C........320 Townsend St., Lansing 48933
Stanley, Arthur L......401 W. Greenlawn, Lansing 48910
Stehman, Vernon A......Lewis Cass Bldg., Lansing 48913
Steiner, Abraham A. (R)....Route 3, Grand Ledge 48837
Stephan, Winton E.........432 S. Walnut, Lansing 48933
Stilwill, Geo. D.......2909 E. Grand River, Lansing 48912
Stimson, Paul R...119 E. Grand River, East Lansing 48823
Stone, Benj. J. (A)................736 Rosewood Ave., East Lansing 48823
Stow, Robt. M.......2909 E. Grand River, Lansing 48912
Strempek, Walter F.................726 Whitehills Dr., East Lansing 48823
Stringer, C. J. (R)....425 Walbridge, East Lansing 48823
Sundell, Edwin C...1322 E. Michigan Ave., Lansing 48912
Swartz, Fredk. C......720 Seymour Street, Lansing 48906
Tamblyn, Fredk. W.....335 Seymour Ave., Lansing 48933
Thaden, D. W.......909 Abbott Rd., East Lansing 48823
Thimmig, Robt. F...1322 E. Michigan Ave., Lansing 48912
Tien, Hsin Chen........701 N. Logan St., Lansing 48915
Trager, Fredk. C...1322 E. Michigan Ave., Lansing 48912
Trescott, Robt. F...1322 E. Michigan Ave., Lansing 48912
Trimby, Robt. H...1322 E. Michigan Ave., Lansing 48912
Troost, Franklin L.........4378 W. Delhi Rd., Holt 48842
Turner, Paul C...2909 E. Grand River 203, Lansing 48912
Urban, Eva...........540 Glenmoor, East Lansing 48823
Vanderzalm, T. P. (L)............1452 Cambridge Rd., Lansing 48910
Varner, Carol......Okemos Medical Bldg., Okemos 48864
Velten, Hubert P.......401 W. Greenlawn, Lansing 48910

Venier, Jos. H. 1628 Hitching Post Rd., East Lansing 48823
Wadley, Ralph.........335 Seymour Ave., Lansing 48933
Walker, Leo W.....4225 Apple Tree Lane, Lansing 48917
Weber, William.......401 W. Greenlawn, Lansing 48910
Wellman, John M...1322 E. Michigan Ave., Lansing 48912
West, Chas. Carl.....2909 E. Grand River, Lansing 48912
Wiegenstein, John G...2025 W. Holmes Rd., Lansing 48910
Wilcox, K. R., Jr....Mich. Dept. of Health, Lansing 48906
Wilensky, Thos.........701 N. Logan St., Lansing 48915
Willson, Howard S...704 Mich. Nat. Tower, Lansing 48933
Worthington, Ralph......810 W. Saginaw, Lansing 48915
Wortley, Chas. K.................1017 E. Grand River, East Lansing 48823
Zick, Gerald A.....1322 E. Michigan Ave., Lansing 48912
Ziel, Hermann A., Jr.............Mich. Dept. of Health, Lansing 48906

IONIA-MONTCALM COUNTY MEDICAL SOCIETY (94)

Anderson, D. Hess........207 Bridge St., Portland 48875
Bautista, Leandre I......910 E. Lincoln Ave., Ionia 48846
Bennett, W. Bruce....Lakeview Hospital, Lakeview 48850
Bird Wm. L...........917 W. Oak St., Greenville 48838
Birzgalis, Alfreds A........Ionia State Hosp., Ionia 48846
Buck, Jack H..................517 Division, Ionia 48846
Bunce, Leo W...........................Trufant 49347
Campbell, Richard E..........106 N. Depot, Ionia 48846
Colon-Bonet, Cesar H..............Lakeview Med. Ctr., Lakeview 48850
Dunkin, Lloyd S........410 S. Clay St., Greenville 48838
Foust, Jos. C. (A)................Kisa Box 73 Tukuyu, Tanganyika, E. Africa
Geib, Oscar P. (L).......................Gaylord 49735
Guner, Ali..........Alpena General Hosp., Alpena 49707
Halick, John...........200 S. Franklin, Greenville 48838
Hansen, Carl M.........................Stanton 48888
Haskell, Robt. H. (L)..........Zetlands Estate T.W.R., Nevis, Leeward Isl., B.W.I.
House, Glenn W., Jr....1200 W. Oak St., Greenville 48838
Kazmers, Nikolas.......................Lakeview 48850
Kopchick, Jos.............................Muir, 48860
Kozachik, Martin J.........123 Bridge St., Portland 48875
Leach, Russell E......R. 1 Clarksville Rd., Portland 48875
Lilly, Isaac S. (L)........................Stanton 48888
London, John L...Lakeview Medical Ctr., Lakeview 48850
Marston, Leo L...............Box 235, Lakeview 48850
Merchun, Frank A............11804 W. Carson City Rd., Greenville 48838
Mitchell, Harold C. (R).............Box 3175 Nalcrest, East Lake Wales, Fl. 33853
Naglins, Jekabs...........Ionia State Hosp., Ionia 48846
Olsen, Bruce C.........917 W. Oak St., Greenville 48838
O'Malley, R. J.................310 Main St., Ionia 48846
Pates, Don C............122 E. Congress, Belding 48809
Rice, Robt. E............P. O. Box 271, Greenville 48838
Robertson, Perry C. (L)......327 Center St., Ionia 48846
Rottman, G. Jay.....200 S. Franklin St., Greenville 48838
Sanford, Louis E............219 Main St., Belding 48809
Slagh, Milton E.........................Saranac 48881
Smith, Robt. O..........910 E. Lincoln Ave., Ionia 48846
Socha, Edmund S..............217 E. Main, Ionia 48846
Stevens, Charles E...513 N. Lafayette St., Greenville 48838
Tannheimer, John F........525 Lafayette St., Ionia 48846
Varol, Adnan....12843 Via Catherina, Grand Blanc 48439
Younis, Ahmad.....505 S. Lafayette St., Greenville 48838

JACKSON COUNTY MEDICAL SOCIETY (98)

Adams, Ellis W..........720 W. Franklin, Jackson 49201
Ahronheim, J. H.....Foote Memorial Hosp., Jackson 49201
Ahronheim, Gerald (M)
Allen, Duane M.....Hanover Medical Ctr., Hanover 49241
Appel, Saul........112 W. Michigan Ave., Jackson 49201
Baker, Geo. M................350 S. Union, Parma 49269
Beckwith, Sidney A....100 E. Main St., Stockbridge 49285
Bentley, Jack P.....2532 Spring Arbor Rd., Jackson 49203
Bentley, Mary E. N., 2532 Spring Arbor Rd., Jackson 49203
Betts, Joseph S..........502 Lansing Ave., Jackson 49201
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Ludwick, John P......237 W. Washington, Jackson 49201
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McLaughlin, Miar J. (L)..710 S. Brown St., Jackson 49203
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Oleksy, Stanley P........744 W. Michigan, Jackson 49201
Olsen, Lloyd L.....610 W. Michigan Ave., Jackson 49201
Oster, Harold L...........1514 Fourth St., Jackson 49203
Otis, Grant L.........525 Wildwood Ave., Jackson 49201
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Bodmer, Harvey C.............403 W. Kalamazoo Ave., Kalamazoo 49006
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Harrell, Frank G.........1602 Gull Rd., Kalamazoo 49001
Harrelson, Wm. D........1324 S. Park, Kalamazoo 49001
Hayner, Russell A........4015 Portage, Kalamazoo 49001
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Machin, Harold A.........420 John St., Kalamazoo 49006
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Thompson, Athol B. (L) . . . . 1857 Golden Rain Rd., Walnut Creek, Ca. 94529
Thompson, Edward C. . . . . 153 Lafayette Ave. S.E., Grand Rapids 49503
Thompson, Frank D. . . . . 2008 El Dorado Dr. S.E., East Grand Rapids 49506
Tiffany, Jos. C. . . . . 502 Medical Arts Bldg., Grand Rapids 49501
Tomatis, Luis A. . . 456 Cherry St. S.E., Grand Rapids 49503
Torgerson, Wm. R. . . . . Ramona Medical Center, Grand Rapids 49506
Townsend, Jack H. . . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Troske, Robt. L. . . . . . . 534 Dogwood Dr. N.E., Ada 49301
Truog, Clarence P. . . 110 Fulton St. E., Grand Rapids 49502
Turcotte, V. J., Jr. . . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Vaandrager, Vernon D. . . . . 245 State St. S.E., Grand Rapids 49502
Valdmanis, F. . . . . 2120 Lake Dr. S.E., Grand Rapids 49506
Vanden Berg
Van Bree, Raymond S. . . . . 812 Rosalie N.W., Grand Rapids 49504
Van Dam, Forrest R. . . . . 1810 Wealthy St. S.E., Grand Rapids 49506
Vanden Berg, A. R. 833 Lake Dr. S.E., Grand Rapids 49506
Vandenberg, Wm. . . 124 Fulton St. E., Grand Rapids 49502
Vanden Berg, Wm. O. . . . . 50 College Ave. S.E., Grand Rapids 49503
Vander Kolk, K. J. . . . . 2740 Eastern Ave. S.E., Grand Rapids 49507
Vander Meer, Raymond . . . . 26 Sheldon Ave., S.E., Grand Rapids 49502
Vandermolen, John . . 124 Fulton St. E., Grand Rapids 49502
Vander Ploeg, R. A. . . . . 26 Sheldon Ave. S.E., Grand Rapids 49502
Vander Ploeg, Wm. H. . . . . 833 Lake Dr. S.E., Grand Rapids 49506
Van Der Veer, Corwin G. . . . . 245 State St. S.E., Grand Rapids 49503
Van Dommelen, G. M. . . . . 245 State St. S.E., Grand Rapids 49502
Van Duine, Henry J. . . . . 153 Lafayette S.E., Grand Rapids 49503
Van Dyke, Harold E. . . . . 1108 Leonard St. N.E., Grand Rapids 49503
Van Etten, Donald D. (A) . . Box 1, Bahrain, Arabian Gulf
Van Goor, Kornelius . . . . 26 Sheldon Ave. S.E., Grand Rapids 49502
Van Otteren, G. F. . . . . 245 State St. S.E., Grand Rapids 49502
Van Portfliet, Paul . . 245 State St. S.E., Grand Rapids 49503
VanSolkema, Andrew A. . . . . 953 E. Fulton St., Grand Rapids 49503
Van't Hof, Albert . . . . 50 College Ave. S.E., Grand Rapids 49503
Van Vliet, Peter D. . . . . 100 Michigan St. N.E., Grand Rapids 49503
Van Woerkom, Danl. . . . . 933 Leonard St. N.W., Grand Rapids 49504
Van Zwalenburg, B. R. . . . . 2116 Coronado Dr. S.E., Grand Rapids 49506
Vasu, C. Mark . . 833 Lake Drive S.E., Grand Rapids 49506
Veldman, Harold E. . . 26 Sheldon Ave., Grand Rapids 49502
Veltman, Jay H. . . . . . . 3946 G 30th St., Grandville 49418
Venema, Jay R. . . . . 540 Overbrook Lane S.E., Grand Rapids 49507
Ver Lee, Jimmie J. (A) . . . . Galmi Hospital, Galmi Via Madaoua, Niger Republic, West Africa
Ver Meulen, John (L) . . . . 2501 Central Ave. S.W., Grand Rapids 49509
Ver Meulen, Peter (A) . . . . 105 Baynton N.E., Grand Rapids 49503
Verwys, A. L. Hubert . . . . 815 Alger St. S.E., Grand Rapids 49507
Vining, Keats K., Jr. . . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Vis, William R. (L) . . . . 26 Sheldon Ave. S.E., Grand Rapids 49502
Visscher, H. C. 515 Lakeside Dr. S.E., Grand Rapids 49506
Visscher, Robert D. . . . . 515 Lakeside Drive S.E., Grand Rapids 49506
Visser, Earl R. . . . . 530 Overbrook Lane S.E., Grand Rapids 49507
Vogel, Anton . . . . 1204 Madison Ave. S.E., Grand Rapids 49507
Volkel, James S. . . . . 833 Lake Drive S.E., Grand Rapids 49506
Voss, John A. . . . . 2410 Gaynor Ave. N.W., Grand Rapids 49504
Vroon, John . . . . 50 College Ave. S.E., Grand Rapids 49503
Vyn, Jay D. (L) 7119 Driftwood S.E., Grand Rapids 49506
Wahby, Elmer F. . . . . 100 Michigan St. N.E., Grand Rapids 49503
Walma, Daniel . . . . 26 Sheldon Avenue S.E., Grand Rapids 49502
Wassink, Roger N. . . . . 26 Sheldon Ave. S.E., Grand Rapids 49502
Waterman, Donald F. . . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Webb, Clarence F. 833 Lake Dr. S.E., Grand Rapids 49503
Webber, Jerome E. . . . . 50 College Ave. S.E., Grand Rapids 49503
Weeber, Thomas A. . . 3011 Wilson S.W., Grandville 49418
Wehrenberg, R. A. (A) . . . . Pleasure Bay, Apt. 5, Long Branch, N.J. 07740
Weller, Keith E. . . . . 1200 Lake Drive S.E., Grand Rapids 49506
Wendt, Vernon E. . . . . 937 Fulton St. W., Grand Rapids 49504
Westendorp, Floyd . . . . 6850 Division Ave. S., Grand Rapids 49508
Westerhoff, Robert J. . . . . 2740 Eastern Ave. S.E., Grand Rapids 49507
Whinery, Jos. F. 50 College Ave. S.E., Grand Rapids 49503
Whitehouse, John D. . . . . 1201 Colorado Ave. S.E., Grand Rapids 49506
Whittenberger, R. N. . . . . 245 State St. S.E., Grand Rapids 49503
Wiese, John L. . . 50 College Ave. S.E., Grand Rapids 49503
Wilcox, Rex G. (A) . . . . 1045 Keneberry Way S.E., Grand Rapids 49506
Wilderom, Morris . . . . 1619 Walker St. N.W., Grand Rapids 49504
Wilkes, John B. . . . . 1328 Madison Ave. S.E., Grand Rapids 49507
Wilkinson, C. A. . . . . 2030 Leonard St. N.W., Grand Rapids 49504
Williams, John R. . . 833 Lake Dr. S.E., Grand Rapids 49506
Wilson, John R. 1033 Fulton St. West, Grand Rapids 49503

Wilson, Robert J...1011 Fulton St. E., Grand Rapids 49503
Winfield, Emery D. (L)..............457 Burton S.E., Grand Rapids 49507
Winter, Garrett E.............1967 Godfrey Ave. S.W., Grand Rapids 49509
Wright, Thos B. (A)..........2614 Plainfield Ave. N.E., Grand Rapids 49505
Wurz, John F..................201 Norwood Ave. S.E., Grand Rapids 49506
Wyngaarden, Martin K..............245 State St. S.E., Grand Rapids 49503
Yared, Jerome A...651 Cherry St. S.E., Grand Rapids 49506
Yost, William G., Jr...............50 College Ave. S.E., Grand Rapids 49503
Young, Donald G...............100 Michigan St. N.E., Grand Rapids 49503
Zadvinskis, Z.....833 Lake Dr. S.E., Grand Rapids 49506
Zimmerman, Wm. G..............26 Sheldon Ave. S.E., Grand Rapids 49502
Zwemer, Rodger J..............1810 Wealthy St. S.E., Grand Rapids 49506

LAPEER COUNTY MEDICAL SOCIETY (110)

Abruzzo, Anthony M....Lapeer State Home, Lapeer 48446
Berker, Isak O..............South Street, Davison 48423
Bishop, G. Clare..........................Almont 48003
Boruch, Leon R.............Drawer A, Lapeer St. Hme., Lapeer 48446
Conaway, Chas. E........1257 N. Main St., Lapeer 48446
Dorland, Clarke...........221 Lincoln St., Lapeer 48446
Doty, James R...............315 Clay St., Lapeer 48446
Greavu, Cornell, Jr..................North Branch 48461
Haney, M. Bennet.....409 E. St. Clair St., Almont 48003
Heitsch, Wm. C.........3257 Davison Rd., Lapeer 48446
House, Clifford............1750 Grey Rd., Lapeer 48446
Kiehler, E. G., II.........3257 Davison Rd., Lapeer 48446
Kim, S. J.....1401 S. Washington Ave., Royal Oak 48067
Kocur, Lubomira...............Drawer A, Lapeer 48446
Lebedovych, Emil............Drwr. A, Lapeer S. Home, Lapeer 48446
Lebedovych, Ksenia.........Drawer A, Lapeer S. Home, Lapeer 48446
Leith, Dorothy L.........240 Main St., Imlay City 48444
Lopez, Leonardo V. (A)....295 W. Huron, Pontiac 48053
Lynk, Stanley M..........4589 Lippincott, Lapeer 48446
McBride, John R........431 Washington St., Lapeer 48446
Smith, Ellen (A)...................400 White Rd., R. 1, Columbiaville 48421
Smith, Glenn L.....6552 Imlay City Rd., Imlay City 48444
Ucer, Erol (A).......2835 W. Genesee St., Lapeer 48846
Zemmer, H. R................N. Main St., Lapeer 48446
Zolliker, Carl R. (R)......3646 Slattery Rd., Lum 48452

LENAWEE COUNTY MEDICAL SOCIETY (114)

Abraham, A. O..........................Hudson 49247
Allen, Russell A.......415 W. Maumee St., Adrian 49221
Armovit, Herminio........236 S. Fourth St., Onsted 49265
Bachman, Joseph F.............602 E. Pottawatamie St., Tecumseh 49286
Balice, F. W..............128 E. Butler St., Adrian 49221
Baylon, Leonardo.........231 N. Main St., Adrian 49221
Benz, Carl A..............308 N. Broad St., Adrian 49221
Berghuis, John.........225 Riverside Ave., Adrian 49221
Blanchard, Lowell E....................Hudson 49247
Blanden, Merwin R..................Tecumseh 49286
Boyd, James W.......4510 Southgate Lane, Adrian 49221
Burch, Larry T...........10 Cairns St., Tecumseh 49286
Coak, Richard D...............602 E. Pottawatamie St., Tecumseh 49286
Cook, Carlton L....603 E. Pottawatamie, Tecumseh 49286
Cooper, James H..........308 N. Broad St., Adrian 49221
Diccion, R. A..........................Morenci 49256
Dickman, Harry M...........104 Oak St., Hudson 49247
Dustin, Richard E.....103 W. Brown St., Tecumseh 49286
Eddy, Howard R. G..............Mill Rd., Adrian 49221
Feeney, James L................Mill St., Adrian 49221
Galliani, M............4410 Evergreen Dr., Adrian 49221
Gamble, Kenneth..................R. 3, Hudson 49247
Gascoigne, Richard H....693 Stockford Dr., Adrian 49221
Gilkey, William C.....693 Stockford Drive, Adrian 49221
Gilmartin, Richard................Mill St., Adrian 49221
Greiner, Robert A........Professional Bldg., Adrian 49221
Hamilton, John..................Mill St., Adrian 49221
Hamilton, Thomas........113 W. Front St., Adrian 49221
Hammel, Richard T....611 N. Evans St., Tecumseh 49286
Hammersley, Gordon.....1361 Oregon Rd., Adrian 49221
Harrison, Robt. E.........418 W. Adrian, Blissfield 49228
Heffron, Chas H...........231 N. Main St., Adrian 49221
Heffron, G. Harold (L)....231 N. Main St., Adrian 49221
Heffron, Howard H........231 N. Main St., Adrian 49221
Helzerman, Ralph F...112 S. Ottawa St., Tecumseh 49286
Hewes, Wm. H..................Mill Rd., Adrian 49221
Hunt, Philip.....................Mill St., Adrian 49221
Locke, Francis A.............755 High St., Adrian 49221
Marsh, Roland G. B. (L)..............1938 Spruce St., Boulder, Co. 80302
Miller, P. Lynford......310 E. Maumee St., Adrian 49221
Ocamb, Harold D...600 E. Pottawatamie, Tecumseh 49286
Parker, Donald A...........Bixby Hospital, Adrian 49221
Patmos, Bernard.........127 E. Maumee St., Adrian 49221
Phelan, Alvin J................10 Cairns, Tecumseh 49286
Purfield, Wm. P.....................Manchester 48518
Raabe, Elmer G.........................Morenci 49256
Richey, Bert R.....765 Manitou Rd., Manitou Beach 49253
Sarapo, Donato F..................Mill St., Adrian 49221
Shannon, Gordon (A).................Blissfield 49228
Skufis, Eleanor P..........201 Orchard Rd., Adrian 49221
Skufis, Xenophon..........123 E. Chestnut, Adrian 49221
Stewart, Landis C............750 High St., Adrian 49221
Taylor, Richard L.......Emma Bixby Hosp., Adrian 49221
Van Dusen, Chad A. (L).......R.F.D. 5, Blissfield 49228
Wentz, Patricia..............760 Riverside, Adrian 49221
White, Robert B.............945 Riverside, Adrian 49221
Whitehouse, Keith H...................Morenci 49256
Wilson, Geo. C..................Box 224, Clinton 49236
Wolf, Marvin B..........689 Stockford Dr., Adrian 49221
Wynn, Geo. H...........1115 W. Maumee, Adrian 49221

LIVINGSTON COUNTY MEDICAL SOCIETY (118)

Barton, Thos. A..........116 N. Michigan, Howell 48843
Clarke, Niles A..........624 Spencer Rd., Brighton 48116
Damstra, Donald L. 12893 E. Grand River, Brighton 48116
Duffy, Ray M. (L)........P.O. Box 106, Pinckney 48169
Granowski, Karol..........McPherson Comm. Hlth. Ctr., Howell 48843
Harebottle, Norman..................Fowlerville 48836
Hauer, R. Fred.........................Fowlerville 48836
Hendren, Jesse J. (R)................Fowlerville 48836
Higby, Thomas F.....................Fowlerville 48836
Hill, Harold C.......116 N. Michigan Ave., Howell 48843
Hoffman, Stanley L.......1200 Byron Road, Howell 48843
May, Louis E...............City Route 4, Howell 48843
Perry, Florence J. C...............17640 San Rose Ave., Lathrup Village 48075
Phillips, R. W.........................Hamburg 48139
Polack, Robt. T.........1215 Lakeside Dr., Howell 48843
Schenden, A. J. (R)......2753 Page St., Ann Arbor 48104
Sheng, Luke H. C....111 W. Grand River, Brighton 48116
Stuber, Roscoe V..........1200 Byron Rd., Howell 48843
Walker, Enos G......4485 Cordley Lake, Lakeland 48143
Wang, Stella K. G.......111 Grand River, Brighton 48116
Woodworth, Edwin S......1200 Byron Rd., Howell 48843

LUCE COUNTY MEDICAL SOCIETY (122)

Eadie, Gordon A..............Est. Upper Health Dept., Newberry 49868
Gibson, Robt. E. L., Jr...207 W. John St., Newberry 49868
Grennan, Lawrence E. (A)........1344 Northlawn N.E., Grand Rapids 49505
Hicks, R. P.............210 W. John St., Newberry 49868
Kearney, Martin J. Newberry State Hosp., Newberry 49868
Keizer, B. G.......Newberry State Hosp., Newberry 49868
Purmort, Wm. R., Jr.............Newberry State Hosp., Newberry 49868
Thompson, Thos. W..............Crescent Shores, Rt. 2, Traverse City 49684

MACOMB COUNTY MEDICAL SOCIETY (126)

Alejos, Juan E...31225 E. Jefferson, St. Clair Shores 48082
Alexander, James H...25815 Harper, St. Clair Shores 48081
Alvarez, Mercedes
Ambrose, Robt. H. 18801 E. Ten Mile Rd., Roseville 48066
Arellano, Miguel A......21500 Mound Rd., Warren 48091
Audretsch, F. E...........355 Lincoln, Grosse Pte. 48230
Barker, John G.....8050 Warren Blvd., Center Line 48015
Beecher, Alvin J.........21501 Kelly, East Detroit 48021
Bigley, Bernard........35992 Gratiot, Mt. Clemens 48043
Biluk, Frank J..........GM Tech. Center, Warren 48092
Bishai, Yousef B. 11477 E. Twelve Mile Rd., Warren 48093
Bond, Franklyn F...4861 E. Nine Mile Rd., Warren 48091
Bower, Allen B. (L)....................Armada 48005
Brown, Leland C....21536 Parkway, St. Clair Shores 48082
Bryce, James W. 25219 Van Dyke Ave., Center Line 48015
Carruthers, W. B.......198 S. Gratiot, Mt. Clemens 48043
Chabator, George........294 Benjamin St., Romeo 48065
Charbeneau, Harold P...229 S. Gratiot, Mt. Clemens 48043
Charbonier, Luis M...........11868 E. Eleven Mile Rd., Warren 48089
Clay, Joel W.......263 S. Gratiot Ave., Mt. Clemens 48043
Cohen, Alan.......12500 Twelve Mile Rd., Warren 48093
Cohen, Alberto.....25705 Stonycroft Dr., Southfield 48075
Colah, Sorab A.................708 Monitor Leader Bl., Mt. Clemens 48043
Collon, David (A) D.D.S.................Romeo 48065
Copping, James W., Jr..................St. Joseph Hosp., Mt. Clemens 48043
Corbett, John.........225 S. Gratiot, Mt. Clemens 48043
Cosio, Jose.......St. Joseph Hospital, Mt. Clemens 48043
Croman, Jos. M., Jr. (R)...............131 Market St., Mt. Clemens 48043
Curatolo, Victor......67 Cass Ave., Mount Clemens 48043
Darian, H. B........11528 E. 12 Mile Rd., Warren 48093
Deal, Harold R..........23700 Van Dyke, Warren 48089
Deocampo, E.......20720 Maxine, St. Clair Shores 48080
Deocampo, Nestor D.............11477 Twelve Mile Rd., Warren 48093
Depaulis, Dario C........22770 Kelly, East Detroit 48021
Dragulescu, Paul.......27440 Hoover Rd., Warren 48093
Dudzinski, Edmund J...............424 Washington St., New Baltimore 48047
Ebner, Charles M..................25520 Little Mack, St. Clair Shores 48081
Ekelman, Seymour B.....14 Belleview, Mt. Clemens 48043
Ellias, Elmer P..........23700 Van Dyke, Warren 48089
Engels, John A..........69311 N. Main, Richmond 48062
Erkfitz, Arthur W...................26401 Harper Ave., St. Clair Shores 48081
Finn, James Wm...............46056 Cass, Utica 48087
French, Lawrence W.......................25815 Harper, St. Clair Shores 48081
Friedman, Herbert F.............13087 Eleven Mile Rd., Warren 48093
Fulgenzi, Andrew A............17301 E. Eight Mile Rd., East Detroit 48021
Gerbasi, Francis..................81 Lochmoor Blvd., Grosse Pte. Shs. 48236
Gesser, Charles................17800 E. Eight Mile Rd., Harper Woods 48236
Goldin, Morris I.........6902 Chicago Rd., Warren 48092
Goldman, Bernard J..................243 S. Gratiot Ave., Mt. Clemens 48043
Gonzalez, C. G.........20 Parkview, St. Joseph Hospital, Mt. Clemens 48043
Gonzalez, Salvador.........................1756 Alland, Grosse Pointe Woods 48236
Hahne, Otto H...8425 E. Twelve Mile Rd., Warren 48093
Hartmann, Waldemar B................1416 S. Gratiot, Mount Clemens 48043
Hiller, Herbert M.............13500 E. Twelve Mile Rd., Warren 48093
Hirzel, Leon S..............33080 Garfield, Fraser 48026
Horvath, Julius........18847 Rosetta, East Detroit 48021
Hoski, Joseph A...8425 E. Twelve Mile Rd., Warren 48093
Hranchook, Michael......30001 Van Dyke, Warren 48093
Hull, Frank J....728 Canterbury, Grosse Pte. Woods 48236
Iglesias, Ernesto R..............608 Monitor Leader Bl., Mt. Clemens 48043
Isaacs, Eli M..........14230 Greenbriar, Oak Park 48237
Isbey, Edward K.....25020 Van Dyke, Center Line 48015
Ivkovich, Peter (A)....12501 E. 23 Mile Rd., Utica 48087
Jacobs, Manuel......23700 Van Dyke Ave., Warren 48089
Jewell, James H...Roseville Theatre Bldg., Roseville 48066
Kane, John P.........67 Cass Ave., Mount Clemens 48043
Kane, Peter V........67 Cass Ave., Mount Clemens 48043
Kane, Wm. J. (L)..171 North Avenue, Mt. Clemens 48043
Katzman, Harold L...13500 E. 12 Mile Rd., Warren 48093
Key, Robin S....25020 Van Dyke Ave., Center Line 48015
Kingsley, Joyce W., Jr...............18801 Ten Mile Rd., Roseville 48066
Kipp, Paul R...........14 Belleview, Mt. Clemens 48043
Kirtland, Wm. B., Jr.............18801 E. Ten Mile Rd., Roseville 48066
Klein, Alfred A..........23700 Van Dyke, Warren 48089
Knoblauch, K. H...8425 Twelve Mile Rd. E., Warren 48093
Kokeny, Wm. J.....23700 Van Dyke Ave., Warren 48093
Kommel, Richard M....................26510 Dundee, Huntington Wds. 48070
Krieger, Bruce..............15250 Park, Oak Park 48237
Krieger, Harvey A...13500 12 Mile Rd. E., Warren 48093
Kripke, Morton J...........11255 Hall Rd., Utica 48087
Kroon, Joseph D.......37984 Bonkay, Mt. Clemens 48043
Kuntzman, Carl E.............260 Estld. Ctr. Prof. Bld., Harper Woods 48236
Kurtz, Hyman (A)....21414 Hillside, Mt. Clemens 48043
Kypros, George P. 26401 Harper St., St. Clair Shores 48081
Laporte, Lawrence A................356 N. Clifton Rd., Birmingham 48010
Lapp, Charles.............7817 McClellan, Utica 48087
Lee, Thomas E......13403 E. 13 Mile Rd., Warren 48093
Levi, Charles....8262 E. Twelve Mile Rd., Warren 48093
Llaneza, Onofre B..................21420 Harper Ave., St. Clair Shores 48080
Lubera, Richard J...................25520 Little Mack, St. Clair Shores 48081
Lublin, Ann.............5224 St. Antoine, Detroit 48202
Maguire, Andrew J.........45569 Van Dyke, Utica 48087
Marinelli, Ralph..8252 E. Twelve Mile Rd., Warren 48093
Mark, Hansi.........8236 E. 12 Mile Rd., Warren 48093
Martin, Wm. L..............117 S. Main St., Romeo 48065
Mattes, Max W..........18456 Wildemere, Detroit 48221
Matthews, C., Jr.........14 Belleview, Mt. Clemens 48043
Maxim, Edward S.......225 S. Gratiot, Mt. Clemens 48043
Mayer, Mary L......715 S. Rogers, Apt. 19, Mason 48854
McGinty, John D......243 S. Gratiot, Mt. Clemens 48043
McMorrow, Kathryn..........28526 Hoover, Warren 48093
Menczer, Richard......31170 Hoover Rd., Warren 48093
Merametdjian, Krikor....22841 Van Dyke, Warren 48089
Merritt, Jule J...36640 S. Gratiot Ave., Mt. Clemens 48043
Messmer, Harold O..........7817 McClellan, Utica 48087
Meyers, Sidney S...........28477 Hoover, Warren 48093
Miller, Sidney S.........28477 Hoover Rd., Warren 48093
Moore, Geo. F. (L)....69434 N. Forest, Richmond 48062
Morris, Gerald W.......14 Belleview, Mt. Clemens 48043
Mulligan, Philip T..............612 Monitor Leader Bl., Mount Clemens 48043
Nance, Marion E........33080 Garfield Rd., Fraser 48026
Nutting, Helen M.................22631 Greater Mack, St. Clair Shores 48080

Ornstein, Chas.......21701 Kelly Rd., East Detroit 48021
O'Shee, Vincent..8216 E. Twelve Mile Rd., Warren 48093
Oughtred, Orville....26401 Harper, St. Clair Shores 48081
Pacho, Marc................27075 Gail, Warren 48093
Paris, Delmo A....18801 E. Ten Mile Rd., Roseville 48066
Parmelee, N. H.......52080 Van Dyke Ave., Utica 48087
Perez, Florence...............27075 Gail, Warren 48093
Porretta, Anthony C..................2112 Venier Rd., Grosse Pte. Wds. 48236
Pugliesi, Frank J.....20927 Kelly Rd., East Detroit 48021
Ragheb, Moufid..............705 N. Valley Chase Rd., Bloomfield Hills 48013
Rakotz, Gerald....13087 Eleven Mile Rd., Warren 48093
Ramos, Antonio E.......29846 Schoenherr, Warren 48093
Reitzel, Rufus H...................199 S. Gratiot Ave., Mount Clemens 48043
Revere, Jos. O...192 S. Gratiot Ave., Mount Clemens 48043
Riddle, Charles B..............620 Eastland Prof. Bld., Harper Woods 48236
Rinkenberger, E. A.................243 S. Gratiot Ave., Mt. Clemens 48043
Rivkin, Jos..........14 Belleview, Mount Clemens 48043
Rooney, Robert..........23700 Van Dyke, Warren 48089
Roth, Geo. E.........19136 Mendota Ave., Detroit 48221
Rothman, Arthur M................22422 Gratiot Ave., East Detroit 48021
Rourke, Ronald E...................21503 Harper Ave., St. Clair Shores 48080
Rousseau, Daniel L..............Monitor Leader Bldg., Mt. Clemens 48043
Rush, Wm. E.............St. Johns Hosp., Detroit 48236
Russell, Paul..........198 S. Gratiot, Mt. Clemens 48043
Ryan, Jack.........23700 Van Dyke Ave., Warren 48089
Ryan, Thomas E.....39310 Gary Ave., Mt. Clemens 48043
Salot, Russell F.......67 Cass Ave., Mount Clemens 48043
Sarnacki, Carl J...8425 Twelve Mile Rd. E., Warren 48093
Scher, Jos. N.......130 Cass Ave., Mount Clemens 48043
Scher, Sydney......132 Cass Ave., Mount Clemens 48043
Schmunk, Robert F...136 Cass Avenue, Mt. Clemens 48043
Shawky, Yehya A. 8425 E. Twelve Mile Rd., Warren 48093
Shaya, Ezra S..............31170 Hoover, Warren 48093
Sheppard, Lawrence F............23700 Van Dyke Ave., Warren 48089
Sherbin, Herbert D.............12500 Twelve Mile Rd., Warren 48093
Siegfried, Edward G...............229 S. Gratiot Ave., Mt. Clemens 48043
Silverman, M. P......21321 Harper, St. Clair Shrs. 48080
Simmons, Milton F...........12500 E. Twelve Mile Rd., Warren 48093
Sims, Wm. N........229 S. Gratiot, Mount Clemens 48043
Singer, Nelson.....22100 Gratiot Ave., East Detroit 48021
Stanton, James........225 S. Gratiot, Mt. Clemens 48043
Starbird, Wm. A.........8216 E. 12 Mile, Warren 48093
Starkman, Norris...........28477 Hoover, Warren 48093
Steele, George H.......229 S. Gratiot, Mt. Clemens 48043
Steinberger, Eugene.....23700 Van Dyke, Warren 48089
Stepka, Joseph E..........50551 Van Dyke, Utica 48087
Stief, Kirwin..218 N. Christine Circle, Mt. Clemens 48043
Stone, Julius..........198 S. Gratiot, Mt. Clemens 48043
Stoyka, Charles.....21503 Harper, St. Clair Shores 48080
Stroude, Donald E. (A) D.D.S.....8425 Twelve Mile Rd., Warren 48093
Stryker, Oscar D. (L)............43525 Elizabeth Rd., Mt. Clemens 48043
Sturm, Fredk. A.........76 Lochmoor, Grosse Pte. 48236
Suksta, Adolph W......23350 Gratiot, East Detroit 48021
Suzuki, M...............23700 Van Dyke, Warren 48089
Thompson, Alfred A. 126 Cass Ave., Mount Clemens 48043
Tinkey, L. Leo.....8306 Twelve Mile Rd., Warren 48093
Transue, David (M)..13403 E. 13 Mile Rd., Warren 48093
Urbancic, William......22048 Gratiot, East Detroit 48021
Vaughn, Charles.....................2700 Brandon Rd., Upper Arlington, Oh. 43221
Watts, Fredric.........27440 Hoover Rd., Warren 48093
Weiss, Jack I.......23700 Van Dyke Ave., Warren 48089
Whitley, Alec....21707 Erben Dr., St. Clair Shores 48081
Wilde, Maurice M...........5930 Chicago, Warren 48092
Wiley, D. Bruce (L)..921 Coolidge, Apt. 3, Lansing 48912
Wilson, Norman R. 225 S. Gratiot Ave., Mt. Clemens 48043
Witus, Carl..........21349 Kelly Rd., East Detroit 48021
Wolf, Ervin.....56 Breitmeyer Place, Mt. Clemens 48043
Wyte, Wm. C.....263 S. Gratiot Ave., Mt. Clemens 48043
Yamasaki, Ken..........23700 Van Dyke, Warren 48089
Zavela, Dan......679 N. Renaud, Grosse Pte. Wds. 48236
Zook, Mr. Gilbert E. (A)................253 S. Gratiot, Mt. Clemens 48043
Zucker, Norman.....26401 Harper, St. Clair Shores 48081

MANISTEE COUNTY MEDICAL SOCIETY (130)

Futterer, LeRoy A.....Forest Clinic Bldg., Manistee 49660
Garneau, Robt. R.....Forest Clinic Bldg., Manistee 49660
Gunderson, Edw. R., Jr...Greenbush Street, Manistee 49660
Hansen, Ernest C...........326 First St., Manistee 49660
Kiley, James A...............310 9th St., Manistee 49660
Konopa, John F............57 Poplar St., Manistee 49660
Miller, Ernest B............326 First St., Manistee 49660
Ramsdell, Homer A. (L)...398 River St., Manistee 49660
Rosenow, K. G........Forest Clinic Bldg., Manistee 49660
Schwing, Donald N...Forest Clinic Bldg., Manistee 49660
Wild, David A............84 Cypress St., Manistee 49660

MARQUETTE-ALGER COUNTY MEDICAL SOCIETY (134)

Aeocks, James R...Morgan Hgts. Sanat., Marquette 49855
Amolsch, Arthur L.......1008 Bluff St., Marquette 49855
Bennett, Arthur
Bennett, Matthew C..............1414 W. Fair Avenue, Marquette 49855
Berry, Robt. F....1414 W. Fair Avenue, Marquette 49855
Bertucci, Jos. P.........114 S. First St., Ishpeming 49849
Bolitho, Thos. B...1414 W. Fair Avenue, Marquette 49855
Brish, Adam........1414 W. Fair Ave., Marquette 49855
Bujard, Robert S.....1414 W. Fair Ave., Marquette 49855
Carefoot, Rankin L...............1414 W. Fair Avenue, Marquette 49855
Casler, Wilbur L. (L)..131 E. Ridge St., Marquette 49855
Celori, Luciano.........427 W. College, Marquette 49855
Conley, Donal T...1414 W. Fair Avenue, Marquette 49855
Cooperstock, Moses..1414 W. Fair Ave., Marquette 49855
Corcoran, Wm. A. (L)..............200 S. Main Street, Ishpeming 49849
Elzinga, Donald R...1414 W. Fair Ave., Marquette 49855
Elzinga, Eugene R...............1414 W. Fair Avenue, Marquette 49855
Emani, Firooz......1414 W. Fair Ave., Marquette 49855
English, John W...1414 W. Fair Avenue, Marquette 49855
Flores, R................613 Lake St., Marquette 49855
Green, Southgate J.......................Gwinn 49843
Hopkins, William F...............1414 W. Fair Avenue, Marquette 49855
Hornbogen, Danl. P...............1414 W. Fair Avenue, Marquette 49855
Howe, Lloyd W. (L)..............Savings Bank Bldg., Marquette 49855
Huffman, Elston R...............1414 W. Fair Avenue, Marquette 49855
Humphrey, William C...829 Croix Street, Negaunee 49866
Jaedecke, Robt. G...........829 Croix, Negaunee 49866
Kane, Elizabeth D. (R)..............418 W. Magnetic, Marquette 49855
Koenig, Harry......540 E. Division St., Ishpeming 49849
Kronschnabel, E. F...............1414 W. Fair Avenue, Marquette 49855
Kublin, John C.......1414 W. Fair Ave., Marquette 49855
Lambert, Warren C....347 E. Ridge St., Marquette 49855
Lexmond, M. J........524 Mather Ave., Ishpeming 49849
Lincke, E. T......1414 W. Fair Avenue, Marquette 49855

Lyons, James W.........803 N. 3rd St., Marquette 49855
Matthews, Norman L.............N. Mich. Child Clinic, Marquette 49855
Morris, John C.......1414 W. Fair Ave., Marquette 49855
Mudge, Thomas J...1414 W. Fair Avenue, Marquette 49855
Mudge, Wm. A. (L).....108 Ridge St., Negaunee 49866
Narotzky, Archie S.......Miracle Circle, Ishpeming 49849
Newell, Wilson G........101 S. Fourth, Ishpeming 49849
Niemi, Osmo (R)....................Box 151, Gwinn 49843
Oldham, Earle S....427 W. College Ave., Marquette 49855
Olson, Walter R.........Sand Point Rd., Munising 49862
Pearson, Wallace G...............1414 W. Fair Avenue, Marquette 49855
Pillote, Florence A.....26 Lakeview Dr., Marquette 49855
Pillote, John F.....1414 W. Fair Avenue, Marquette 49855
Potter, Richard.............Marquette Co. Hlth. Dept., Marquette 49855
Rosenbaum, Louis......524 Mather St., Ishpeming 49849
Sabin, Fredk. C...1414 W. Fair Avenue, Marquette 49855
Schmidt, Merle C. (A)................111 W. 39th St., Vancouver, Wa.
Schroeder, W. Gene (M)................524 Mather St., Ishpeming 49849
Schweinsberg, Sara K. D. (A)....507 Bemis Rd. R.F.D., Saline 48176
Tobin, James F., Jr.........724 Elliott, Ishpeming 49849
Van Riper, Paul (L)....................Champion 49814
Wall, David R.......Aitamont & Fisher, Marquette 49855
Williams, Reginald G....524 Mather St., Ishpeming 49849
Wilson, George M., Jr.............1414 W. Fair Avenue, Marquette 49855
Wright, Kenneth C...............1414 W. Fair Avenue, Marquette 49855

MASON COUNTY MEDICAL SOCIETY (138)

Bacon, Herbert G., Jr.......101 N. Main, Scottville 49454
Boon, A. Floyd..........203 N. Ferry, Ludington 49431
Carney, John R.........202 N. Park St., Ludington 49431
Carney, Ruth V. C....202 N. Park Ave., Ludington 49431
Castellani, R. J...........P.O. Box 349, Ludington 49431
Clark, Harry L. (L)..............510 N. Lakeshore Dr., Ludington 49431
Craymer, Austin..........420 N. Rath, Ludington 49431
Ewing, R. L.........600 Tinkham Ave., Ludington 49431
Hoffman, Howard B. 7418 Golfwood Rd., Ludington 49431
Irick, Robert..........Memorial Hosp., Ludington 49431
Kellawan, Karl K.......................Scottville 49454
Kleinschmidt, Gladys J...........401 E. Ludington Ave., Ludington 49431
Martin, Wm. S..........107 Ludington, Ludington 49431
Mayer, Gerry (M)...................2212 McArthur, Colorado Springs, Co. 80909
Morrow, Wm. J.......2511 Elm Ave., Evanston, Il. 60201
Ostrander, Robt. A...2945 E. 1st Street, Tucson, Az. 85716
Paukstis, Chas. A.......111 E. Court St., Ludington 49431
Sutter, Wm. F.........220 S. James St., Ludington 49431
Waun, James........1006 N. Sherman, Ludington 49431

MECOSTA-OSCEOLA-LAKE COUNTY MEDICAL SOCIETY (142)

Asplund, Charles M.......213 Elm St., Big Rapids 49307
Bruggema, Jacob.................Main St., Evart 49631
Davis, Roy A......Ferris State College, Big Rapids 49307
Franklin, Benj. L. (L)...................Remus 49340
Haldeman, Jack......1014 S. State St., Big Rapids 49307
Hickox, Leland A.....1014 S. State St., Big Rapids 49307
Kilmer, Paul B..........102 W. Upton, Reed City 49677
Kowaleski, Edward H.....................Remus 49340
Lincoln, Norman V.......108 E. Upton, Reed City 49677
Merlo, Frank A.....206 S. Michigan St., Big Rapids 49307
Nelson, Lorenzo R............R. F. D. 1, Baldwin 49304
Phelps, Leland B.....111 S. Chestnut St., Reed City 49677
Price, Leonard....Ferris State College, Big Rapids 49307
Pusczak, George B........213 Elm St., Big Rapids 49307
Tyson, James L...1014 South State St., Big Rapids 49307
Van Auken, Edward W...229 S. Warren, Big Rapids 49307
Walters, James E.....1014 S. State St., Big Rapids 49307
White, John A.....121 S. Michigan St., Big Rapids 49307

MEDICAL SOCIETY OF NORTH CENTRAL COUNTIES (150)

Baker, Ophelia P.......199 Fairview, West Branch 48661
Baker, Thomas A.......199 Fairview, West Branch 48661
Blaha, Vernon B.......................Grayling 48738
Boehm, John D. (R)................West Branch 48661
Bontrager, W. E...........................Mio 48647
Christensen, D. E.......N. Mich. TB San., Gaylord 49735
Christensen, Willis L.....617 North Court, Gaylord 49735
Clippert, C. G. (R)...308 Michigan Ave., Grayling 49738
Coulter, Keith D. (R).........P.O. Box 570, Water Isle, U.S. Virgin Islands 00801
Crandell, Clare H. (R)..............West Branch 48661
Dosch, Paul..........................Grayling 49738
Forney, Fred A. (L)
Godfroy, Bernard....................Roscommon 48653
Hayes, Louis F.........................Gaylord 49735
Henig, Benj. E.........................Grayling 49738
Howarth, Thos W......................Gladwin 48624
Jardine, Hugh M....................West Branch 48661
Kieler, George E......................Roscommon 48653
Koltay, Marta Szego............Tolfree Memorial Hosp., West Branch 48661
Koltay, Oscar P.................Tolfree Memorial Hosp., West Branch 48661
Libke, Robert S.........................Gaylord 49735
Oppy, Charles L......................Roscommon 48653
Potvin, Clifford D.....308 Michigan Ave., Grayling 49738
Rusak, R. D...........................Gladwin 48624
Schaiberger, Geo. L..................West Branch 48661
Stealy, Stanley A. (L).................Grayling 49738
Timreck, Harold A.....................Gladwin 48624
Tongco, Rustico C.......617 N. Court St., Gaylord 49735
Van Oosten, Howard E...117 Burgess, West Branch 48661
Wiegerink, L. T......................West Branch 48661

MENOMINEE COUNTY MEDICAL SOCIETY (146)

Agneberg, Nils O..........531 1st St., Menominee 49858
Brukardt, Herman R......534 First St., Menominee 49858
Dewane, Francis J......413 10th Ave., Menominee 49858
Glickman, L. Grant......958 First St., Menominee 49858
Gonty, Arthur..St. Joseph Lloyd Hosp., Menominee 49858
Heidenreich, John R......................Daggett 49821
Hopson, George H. (A)............19186 Santa Barbara, Detroit 48221
Hopson, Patricia C. (A)...........19186 Santa Barbara, Detroit 48221
Jones, Wm. S. (L)....1146 Tenth Ave., Menominee 49858
Jones, Wm. S., Jr......1146 10th Ave., Menominee 49858
Kerwell, Karm C. (L)....P. O. Box 17, Stephenson 49887
Pinkerton, John D.....104 Tenth Ave., Menominee 49858
Towey, John W. (L)................1717 Orchid Lake, Middleton, Wi. 53562

MIDLAND COUNTY MEDICAL SOCIETY (154)

Athay, R. M. (R)......4622 Concord Ct., Midland 48640
Benjamin, Mae B............307 Cass St., Sanford 48657
Bennett, Donald R......3902 Applewood, Midland 48640
Bernier, Jos. A............218 E. Railway, Sanford 48657
Blackhurst, J. F......2715 Ashman Street, Midland 48640
Blackhurst, Robt. T......Blackhurst Bldg., Midland 48640
Bowsher, Robt. E.......4005 Orchard Dr., Midland 48640
Bridge, Robt. G............2715 Ashman, Midland 48640
Bulmer, Dan J..........2707 Ashman St., Midland 48640
Bush, Raymond C........808 W. Sugnet, Midland 48640
Buskirk, Maurice D.......110 W. Sugnet, Midland 48640
Cline, J. Daniel..........920 W. Sugnet, Midland 48640
Devlin, James A.............115 Jerome, Midland 48640
Ellis, Ruth.................2510 Ashman, Midland 48640
Fields, Dozier N., Jr.....515 W. Main St., Midland 48640
Gay, Harold H........Dow Chemical Co., Midland 48640
Goethe, Roy M.......222 N. Saginaw Rd., Midland 48640
Gordon, Harold L.....Dow Chemical Co., Midland 48640
Grant, Robert...........2931 Manor Dr., Midland 48640
Grewe, Norman C........501 E. Pine St., Midland 48640
Haberstroh, Colleen.....3710 Applewood, Midland 48640
Harrigan, William E.......2706 Louanna, Midland 48640
Heffernan, D. D..........402 Dartmouth, Midland 48640
Holder, Benj. B.............Dow Chem. Co. Med. Dept., Midland 48640
Howe, Irvin M...........110 W. Sugnet, Midland 48640
Howell, Richard H.........2707 Ashman, Midland 48640
Ittner, Martin J.......217 N. Saginaw Rd., Midland 48640
Kiyak, Yahya............2216 E. Sugnet, Midland 48640
Kramer, Chas. G...Box 469, Dow Chemical, Midland 48640
Kremski, John A........Midland Hospital, Midland 48640
Kwast, Harold A...........2715 Ashman, Midland 48640
Linsenmann, Karl W.....2604 Manor Dr., Midland 48640
Marks, V. A..............2706 Louanna, Midland 48640
Maynard, Wm. A..........208 N. Fourth, Coleman 48618
Meisel, Edward H., Jr......Masonic Bldg., Midland 48640
Mesaros, Michael P.....44 Ashman Circle, Midland 48640
Moench, G. Fredk.........147 Center St., Sanford 48657
O'Hora, Bernard A.....110 W. Sugnet Rd., Midland 48640
Pike, Melvin H............224 E. Larkin, Midland 48640
Pollock, Robert..........2707 Ashman St., Midland 48640
Poznak, Leonard A.....4005 Orchard Dr., Midland 48640
Randolph, Stephen H. 201 E. Ellsworth St., Midland 48640
Redmon, William B..........115 Jerome, Midland 48640
Sanislow, Charles A.....2707 Ashman St., Midland 48640
Scharf, Forrest........4005 Orchard Dr., Midland 48640
Scharnweber, H. C....Dow Chemical Co., Midland 48640
Schoff, Charles A..........2706 Louanna, Midland 48640
Shipman, Charles W...........2110 16th St. E. Med. Bl., Bay City 48706
Shriner, John W.........902 E. Ashman, Midland 48640
Smith, Donald S., Jr. (M)..2715 Ashman, Midland 48640
Smock, Sidney N.......2200 Eastman Rd., Midland 48640
Towsley, Wilbur D.......515 W. Main St., Midland 48640
Ulmer, George............4005 Orchard, Midland 48640
Van Sickle, Robert L...............222 N. Saginaw Rd., Midland 48640
Westphal, Harry O.........910 Eastlawn, Midland 48640
Willison, Chas. H.......122 Townsend St., Midland 48640
Yobst, G. James...........2719 Ashman, Midland 48640

MONROE COUNTY MEDICAL SOCIETY (158)

Ames, Florence D. (L)..2 W. Noble Ave., Monroe 48161
Barrett, C. D., Sr. (L) 2133 Hollywood Dr., Monroe 48161
Bartolo, Anthony H........757 N. Monroe, Monroe 48161
Black, Charles E.......721 N. Macomb St., Monroe 48161
Blakey, Leonard C......745 N. Monroe St., Monroe 48161
Bond, Wm. W.............222 N. Monroe, Monroe 48161
Burroughs, J. J.........745 N. Monroe St., Monroe 48161
Cigany, Zoltan B........................Carleton 48117
Clark, Bruce........8308 Lewis Ave., Temperance 48182
Costa, Frank..........21941 Woodruff, Rockwood 48173
Diehl, George Z..........721 N. Macomb, Monroe 48161
Douglas, Dale W............124 Cole Rd., Monroe 48161
Dranginis, E. J.........Memorial Hospital, Monroe 48161
Ewing, Robt. T. (L)....130 Maple Blvd., Monroe 48161
Flanders, John P.......753 N. Monroe St., Monroe 48161
Frary, Reginald A..........505 Strasburg, Monroe 48161
Freud, John W.......1262 N. Macomb St., Monroe 48161
Hensel, Hilda M............12 E. 4th St., Monroe 48161
Hnatezuk, Nikolas..8078 Summerfield, Lambertville 48144
Johnson, A. Esther.....751 N. Monroe St., Monroe 48161
Kelso, S. Newton, Jr.........116 Cole Rd., Monroe 48161
King, John R.............12 East 4th St., Monroe 48161
Laboe, Edward W. (R)....424 Hollywood, Monroe 48161
Lammers, Gerald P..........................Ida 48140
Libres, John............753 N. Monroe St., Monroe 48161
Liedel, Warren J...........136 Cole Rd., Monroe 48161
Long, Edgar C.......1310 N. Macomb St., Monroe 48161
Lusher, William T....8308 Lewis Ave., Temperance 48182
McGeoch, Reginald W. (L)........718 N. Macomb St., Monroe 48161
McMillin, John H. (L)....423 E. Elm St., Monroe 48161
Mehregan, Amir H.......12 E. Fourth St., Monroe 48161
Meier, Walter A............134 Cole Rd., Monroe 48161
Middleton, W. S......219 W. Front Street, Monroe 48161
Ozdaglar, Mehmet N......721 N. Macomb, Monroe 48161
Pena, Emilio...........424 Monroe St., Dundee 48131
Pinkus, Hermann K. B.......12 E. 4th St., Monroe 48161
Reisig, Albert H.........1 S. Monroe St., Monroe 48161
Sisman, Bernard............130 Cole Rd., Monroe 48161
Stephenson, Joy O.......15463 S. Monroe, Monroe 48161
Streicher, Robt. G......729 N. Monroe St., Monroe 48161
Tomlinson, Ledyard H.....8718 Main St., Newport 48166
Wagar, Spencer H......31 Washington St., Monroe 48161
Weeks, Vernon L.........749 N. Monroe, Monroe 48161
Wilkins, Rolland W.........118 Cole Rd., Monroe 48161
Williams, Robt. J.......31 Washington St., Monroe 48161

MUSKEGON COUNTY MEDICAL SOCIETY (162)

Aardema, Austin A.......1470 Peck St., Muskegon 49441
Allen, Richard T...768 W. Broadway, Muskegon Hts. 49444
Alt, William J......Medical Arts Center, Muskegon 49440
Annessa, G. W.....Medical Arts Center, Muskegon 49440
Askam, Ralph F.....Medical Arts Center, Muskegon 49440
Atkinson, Annie L................R. 1, Montague 49437
August, Ralph V.......................72 E. Broadway, Muskegon Heights 49444
Barnard, Helen S. (R).............1382 E. Airport Rd., Muskegon 49441
Barnes, James W...102 Professional Bldg., Montague 49437
Barnett, James M. (M)................419 Springwood, San Antonio, Tx. 78216
Benedict, Arthur L., Jr.............22 W. Southern Ave., Muskegon 49441
Bloom, Robt. E.....Medical Arts Center, Muskegon 49440
Bolthouse, Robt. E...2101 Peck St., Muskegon Hts. 49444
Bond, Wm. H..........1282 Arthur St., Muskegon 49442
Boyd, DeVere R..........1735 Peck St., Muskegon 49441
Boyd, Jack L. (A).......1735 Peck St., Muskegon 49441
Bradshaw, Park S...Medical Arts Center, Muskegon 49440
Bultema, James H........1470 Peck St., Muskegon 49441
Busard, J. Max...........1200 Ransom, Muskegon 49442
Busard, Thos. R.....Medical Arts Center, Muskegon 49440
Carlson, Mr. James C. (A) 2060 Belmont, Muskegon 49441
Chapin, Wm. S. (A)....................2136 Sanford, Muskegon Heights 49444
Chiasson, Antonio....4056 Nob Hill Dr., Muskegon 49441
Christophersen, J. W...............1276 Lake Shore Dr., Muskegon 49444
Clapp, Henry W...............202 Westgate Med. Twr., Muskegon 49441
Clifford, James D. (A)......452 Maple, Plymouth 48170
Closz, Harold F. (L)..1727 Jefferson St., Muskegon 49441
Clowater, Robert A....1092 Holton Rd., Muskegon 49440
Cornell, Homer E...303 Medical Arts Ctr., Muskegon 49440
Crawford, John W., Jr.....1470 Peck St., Muskegon 49441
Cronick, Anne B.....435 Whitehall Rd., Muskegon 49445

Dart, Dorothy O. (A)..............428 W. Franklin St., Salisbury, N.C. 28144
Dasler, Adolph F.........1507 Peck St., Muskegon 49441
De Leeuw, Henry....4090 Highgate Rd., Muskegon 49441
DeYoung, Roland W...3800 Monteview, Muskegon 49441
Diskin, Frank.....1324 Marquette Ave., Muskegon 49442
Dykhuizen, H. D...289 W. Western Ave., Muskegon 49440
Ellis, Nicholas J...1891 Lake Shore Dr., Muskegon 49444
Engstrom, Albert D......117 W. Colby, Whitehall 49461
Farmer, John C.....Medical Arts Center, Muskegon 49440
Fillingham, Enid (R)....1034 Giles Rd., Muskegon 49445
Fles, Robt. J.............1715 Peck St., Muskegon 49441
Folsom, John D..........1706 Peck St., Muskegon 49441
Frandsen, Philip H.......1470 Peck St., Muskegon 49441
Fry, Phillip E. (A)..............2774 Patricia, Apt. 10, North Muskegon 49445
Fugate, E. M...206 Westgate Med. Twr., Muskegon 49441
Gaikema, Everett W. (R)................605 First St., North Muskegon 49445
Garber, Frank W., Jr.........1732 Peck, Muskegon 49441
Garber, Frank W. (L)..............235 Monroe Avenue, Muskegon 49441
Garrison, Robt. E., Jr..............210 Med. Arts Bldg., Muskegon 49440
Giese, Douglas H..............305 Westgate Med. Twr., Muskegon 49441
Gillard, James L.........1642 Peck St., Muskegon 49441
Goltz, Martha H. (L)................Montague 49437
Grasman, Erwin.........3068 Wittkop, Muskegon 49440
Griffith, Robt. M....................966 W. Broadway, Muskegon Hgts. 49441
Hack, Donald W....Medical Arts Center, Muskegon 49440
Hanley, Wm. J........315 W. Clay Ave., Muskegon 49440
Harris, W. Richard........852 Winslow, Muskegon 49441
Harryman, James E.....1200 Ransom St., Muskegon 49442
Hartwell, Shattuck W.................Northshore Hosp., North Muskegon 49445
Harvey, John G. Klemm (R)............Mercy Hospital, Muskegon
Heeres, Dale W.....1135 Hampden Rd., Muskegon 49441
Heneveld, John (R)..............Brasstown, N.C. 28902
Heneveld, Robt. G.........1470 Peck St., Muskegon 49441
Hennessy, Mary E. (A) 1200 Ransom St., Muskegon 49442
Herald, Osbie J...............208 Westgate Mdcl. Twr., Muskegon 49441
Holly, Leland E. (L)..889 N. Second St., Muskegon 49440
Holly, Leland E., II..889 N. Second St., Muskegon 49440
Holm, Leo H.....212 Medical Arts Ctr., Muskegon 49440
Hornbeck, Wm. J......1200 Ransom St., Muskegon 49442
Huntley, Richard A..............1704 W. Sherman Blvd., Muskegon 49441
Jesson, Robt. M........1200 Ransom St., Muskegon 49442
Johnston, E. H.......889 N. Second St., Muskegon 49440
Joistad, Arthur H., Jr...889 N. Second St., Muskegon 49440
Kane, Thos. J. (M)................2086 Leimert Blvd., Oakland, Ca. 94602
Kay, Cecelia S...........1533 Peck St., Muskegon 49441
Keilen, Marie (L).....Occidental Hotel, Muskegon 49443
Kerr, Howard J.........3054 Henry St., Muskegon 49444
Kislov, Richard...................1810 Ruddiman Ave., North Muskegon 49445
Kleaveland, Ingram J...1670 Peck Street, Muskegon 49441
Krenz, Marlin P...............Hackley Union Bk. Bldg., Muskegon 49443
Lange, Eugene W. (R).........337 N. Muskegon Blvd., Muskegon 49442
Lauretti, Emil J.....Medical Arts Center, Muskegon 49440
Lauretti, L. A..........936 Second St., Muskegon 49440
Laurin, Vilda S. (L) Medical Arts Center, Muskegon 49440
Le Fevre, Geo. L., Jr. (R)................726 Lake Dr., North Muskegon 49445
Le Fevre, Wm. M. (L) 315 W. Clay Ave., Muskegon 49440
Lemmen, Lloyd J.........1724 Peck St., Muskegon 49441
Leonard, Mr. A. T. (A).............435 Whitehall Rd., Muskegon 49445
Loder, Leonel L...289 W. Western Ave., Muskegon 49440
Lowry, Robt. A.............1470 Peck, Muskegon 49441
Maire, Lewis E..........1633 Peck St., Muskegon 49441
Mandeville, C. B. (L) 5311 N. Bristol, Tacoma, Wa. 98407
Maples, Douglas E........1669 Peck St., Muskegon 49441
Marrs, Jack Winton....Med. Arts Bldg., Muskegon 49440
McNair, John N.........936 Second St., Muskegon 49440
Medema, Paul E.......1017 Sanford St., Muskegon 49440
Meengs, Marvin B........1725 Peck St., Muskegon 49441
Miller, Phillip L..........1755 Peck St., Muskegon 49441
Mulder, Lambertus..Medical Arts Center, Muskegon 49440
Oden, C. L. A. (L)..Medical Arts Center, Muskegon 49440
Oslund, Richard R.....889 N. Second St., Muskegon 49440
Packer, Robert C........4065 Stamford, Muskegon 49441
Parsons, Frank W..............206 Westgate Med. Twr., Muskegon 49441
Paterson, Lester C.........1643 Peek St., Muskegon 49441
Peterson, Wm. F......1094 Jefferson St., Muskegon 49440
Pettinga, Frank L.........1470 Peck St., Muskegon 49441
Risk, Robt. D..........1160 Ransom St., Muskegon 49442
Sanden, Howard V........1643 Peck St., Muskegon 49441
Scholle, Norbert W.............204 Westgate Med. Twr., Muskegon 49441
Shebesta, Emil M...Medical Arts Center, Muskegon 49440
Smith, Robert E....Medical Arts Center, Muskegon 49440
Steffee, William P.................1810 Ruddiman Ave., North Muskegon 49445
Stratton, Donald P.......889 Second St., Muskegon 49440
Stubbart, F. James 2416 Peck St., Muskegon Heights 49444
Stuk, Ronald L. (M)........Dept. Radio., U.S.A. Hosp., Ft. Campbell, Ky. 42223
Swanson, Raymond E.............1315 Ruddiman Ave., North Muskegon 49445
Sweda, George P...............Health Dept., Co. Bldg., Muskegon 49443
Swedenburg, Robt. D...1470 Peck Street, Muskegon 49441
Swenson, Leland L.......1706 Peck St., Muskegon 49441
Tellman, H. Clay.........315 W. Clay, Muskegon 49440
Thornton, Eugene S. (L)..........301 E. Circle Drive., North Muskegon 49445
Torrey, R. K. (M).............Westgate Medical Bldg., Muskegon 49441
Toy, Chas. M............1607 Pine St., Muskegon 49442
Tyler, Wm. H...........1435 Peck St., Muskegon 49441
Vandervelde, C. A.........1470 Peck St., Muskegon 49441
Vangelder, Wm. C...Medical Arts Center, Muskegon 49440
Voikos, Geo. A.........179 Strong Ave., Muskegon 49441
Wagenaar, Edward H...3054 Henry St., Muskegon 49444
Welch, Norman L.........Mercy Hosp., Muskegon 49443
White, Warren G., Jr...........307 Westgate Med. Twr., Muskegon 49441
Wiersma, Silas C. (A)..............University Hospital, Ann Arbor 48104
Wildgen, Bernard C. Medical Arts Center, Muskegon 49440
Wilke, Carl A. (R).............8581 Old Channel Trail, Montague 49437
Williams, Dale L.........1692 Peck St., Muskegon 49441
Williams, Edward V.....................2501 Baker St., Muskegon Heights 49444
Wilson, B. David (A)......15428 Archdale, Detroit 48227
Wohlrabe, J. C.....Medical Arts Center, Muskegon 49440
Wolters, Burton J...103 Medical Arts Ctr., Muskegon 49440
Young, Malcolm C......1700 Clinton St., Muskegon 49442

NEWAYGO COUNTY MEDICAL SOCIETY (166)

Decker, J. C................52 Maple S.E., Grant 49327
DeKryger, Maynard......220 W. Pine St., Fremont 49412
Deur, Theodore R...........52 Maple S.E., Grant 49327
De Young, Jess..........111 W. Dayton, Fremont 49412
Emerick, Robt. W................Box 147, Fremont 49412
Geerlings, Lambert J. (L)..........194 N. Hillcrest Dr., Fremont 49412
Klein, J. Paul.............P.O. Box 111, Fremont 49412
Masters, Brooker L.......111 W. Dayton, Fremont 49412
Painter, Robert..............52 Maple S.E., Grant 49327
Paxton, Robt. E.............220 W. Pine, Fremont 49412
Pedelty, Norman...........38 State Rd., Newaygo 49337
Vanden Berg, Tunis........220 W. Pine, Fremont 49412

NORTHERN MICHIGAN MEDICAL SOCIETY (170)

Allen, Robt. F..........Lockwood Hosp., Petoskey 49770
Alm, Bernhard T.......418 Petoskey St., Petoskey 49770
Bingley, Leo J., Jr.......1018 Lindell St., Petoskey 49770
Blum, Benj. B.......1208 E. Mitchell St., Petoskey 49770
Burns, Dean C................Route 1, Petoskey 49770
Chiu, Robert..............Burns Clinic, Petoskey 49770
Christie, Joseph......P.O. Box 26, Harbor Springs 49740
Connaughton, P. J.........Burns Clinic, Petoskey 49770
Conti, Jos. B.........924 E. Mitchell St., Petoskey 49770
Conway, Wm. S............Burns Clinic, Petoskey 49770
Dawson, William A........Burns Clinic, Petoskey 49770
Drake, Gerald...........511 Waukazoo, Petoskey 49770
Elliott, Dean C............Burns Clinic, Petoskey 49770
Foster, Bradford S.........226 Park Ave., Petoskey 49770
Frye, Sanders A...........Burns Clinic, Petoskey 49770
Grate, Lawrence E........112 Clinton, Charlevoix 49720
Hegener, Aloysius J.....1020 Howard St., Petoskey 49770
Homsi, Rateb.........430 S. Main St., Cheboygan 49721
Kirk, Thomas R.........W. Sheridan Rd., Petoskey 49770
Knecht, Richard A.........226 Park Ave., Petoskey 49770
Kutcipal, R. A...............211 Sunset, Petoskey 49770
Larson, Walter E........456 S. Huron, Cheboygan 49721
Lentini, Nicholas.....................Cheboygan 49721
Lignell, John H.......R. 3, Division St., Charlevoix 49720
Martin, Robt. G...........707 Bridge, Charlevoix 49720
Mateskon, Victor S.........Sunset Blvd., Petoskey 49770
Mayne, Frederick C. (L) P. O. Box 387, Cheboygan 49721
McCullough, W. L........115 Clinton St., Petoskey 49770
McEnroe, John E....1005 E. Mitchell St., Petoskey 49770
McKnight, Robt. D........Lincoln Place, Petoskey 49770
Mertz, Joanne E.............Resort Pike, Petoskey 49770
O'Keefe, N. Thomas (M)....516 Bay St., Petoskey 49770
Peckham, Richard C.......................Gaylord 49735
Postle, Jack R.........Arlington Heights, Petoskey 49770
Rauch, Carl T.......420 Riverside Dr., Cheboygan 49721
Reus, Leonard W.........226 Park Ave., Petoskey 49770
Rodger, John R.........................Bellaire 49615
Ryan, Mary Harmon.......Burns Clinic, Petoskey 49770
Saltonstall, G. B. (L)...112 Clinton St., Charlevoix 49720
Savory, John H.......................East Jordan 49727
Shanahan, Robt. E...1015 Lindell Avenue, Petoskey 49770
Sheets, John A.............929 Michigan, Petoskey 49770
Simard, J. E. Henri....Pennsylvania Plaza, Petoskey 49770
Smith, James R...........901 Spruce St., Petoskey 49770
Snide, Rollin F.......125 N. Main St., Cheboygan 49721
Stringham, James R. (L) 225 Backus St., Cheboygan 49721
Tanton, John H............Burns Clinic, Petoskey 49770
Taylor, Robt. M...........Lincoln Place, Petoskey 49770
Tsaloff, Victor..............Burns Clinic, Petoskey 49770
Uhlich, Gustav A.........E. Mitchell Rd., Petoskey 49770
Van Dellen, Jerrian........Water St., East Jordan 49727
Vanden Brink, R. D.........Burns Clinic, Petoskey 49770
Weber, Richard............Burns Clinic, Petoskey 49770
Webster, Jean H..........200 Sunset St., Petoskey 49770
Weburg, Kathryn D.............Route 3, Petoskey 49770
Zipf, Charles (A)..1326 S. Park Blvd., Freeport, Ill. 61032

OAKLAND COUNTY MEDICAL SOCIETY (174)

Abbott, Vernon C.....1405 Pontiac St. Bk., Pontiac 48053
Abbrecht, Martin M.....800 S. Adams, Birmingham 48011
Adair, Robin..........800 S. Adams, Birmingham 48011
Albert, Donald G...3535 W. 13 Mile Rd., Royal Oak 48072
Albrecht, Robt. W................2111 Cass Lake Rd., Keego Harbor 48033
Alexander, Joseph B. (A)..........900 Woodward Ave., Pontiac 48053
Alkar, Yasar M................159 Pierce St., No. 202, Birmingham 48011
Altshuler, Ira M. (L)..17600 W. 8 Mile, Southfield 48075
Andrakovich, F.......5554 Lahser Rd., Birmingham 48010
Angammal, N. (A)....Pontiac State Hosp., Pontiac 48053
Aragones, James...675 Orchard Lake Ave., Pontiac 48053
Arena, Joseph A., Jr...............31815 Southfield Rd., Birmingham 48009
Arnkoff, Harry..............140 Illinois, Pontiac 48053
Arons, Roy E.......7133 Lindenmere, Birmingham 48010
Ashare, Raymond...........35 S. Johnson, Pontiac 48053
Aulie, Hal G......3535 W. 13 Mile Rd., Royal Oak 48072
Avaregan, Mohsen...........6707 Heather Heath Ln., Birmingham 48010
Awes, Lorraine E...........35 S. Johnson, Pontiac 48053
Axelrod, Robt. G.............3535 W. 13 Mile Rd. 305, Royal Oak 48072
Ayrom, Kambiz........19827 Monte Vista, Detroit 48221
Baier, Kurt....3816 Crestlake Dr., Bloomfield Hills 48013
Baker, Frederick A. (L)..........1936 W. Anklam Rd., Tucson, Az. 85705
Bannow, Robt. J.....880 Woodward Ave., Pontiac 48053
Barker, Chas. P.....214 Wabeek Bldg., Birmingham 48011
Barker, Howard B. (L)................490 Martell Dr., Bloomfield Hills 48013
Barlow, Peter P...31815 Southfield Rd., Birmingham 48009
Barnes, Bradley T........312 Maywood, Rochester 48063
Barnes, Donald J. (L)..20 Norwich, Pleasant Ridge 48069
Barr, Norman L................965 Orchard Ridge Rd., Bloomfield Hills 48013
Barrett, John L....3535 W. 13 Mile Rd., Royal Oak 48072
Barron, Robert A...............4256 Orchard Lake Rd., Orchard Lake 48033
Barsch, Henry J..............21634 E. Valley Wds. Dr., Birmingham 48010
Bauer, Bruce D...22643 S. Chrysler Dr., Hazel Park 48030
Bauer, Edward G........101½ N. Saginaw, Pontiac 48058
Bauer, Ernest W., Sr.............22643 S. Chrysler Dr., Hazel Park 48030
Bauer, E. William 22643 S. Chrysler Dr., Hazel Park 48030
Bauer, Franz.........909 Woodward Ave., Pontiac 48053
Baylis, Shelby M...........35 S. Johnson, Pontiac 48053
Beattie, Willard G. (R).............2500 Sample Rd., Pompano Beach, Fl. 33064
Beck, Otto O. (L)..308 Wabeek Bldg., Birmingham 48011
Becker, Paul M....1890 Southfield Rd., Birmingham 48009
Belknap, Warren F. 1809 S. Main St., Pleasant Ridge 48069
Benjamin, Durand, Jr. (A)........Pontiac General Hosp., Pontiac 48053
Benoit, Merrill P...Pontiac Mtr. Div., GMC, Pontiac 48053
Berg, Richard M......880 Woodward Ave., Pontiac 48053
Berger, Chas. J...17220 W. Eight Mi. Rd., Southfield 48075
Berman, Bernard D. 1200 N. Telegraph Rd., Pontiac 48053
Berman, Gilbert M......24601 Coolidge, Oak Park 48237
Beuker, John T................1100 N. Woodward Ave., Birmingham 48011
Beyer, Hans A........5675 Kolly Rd., Birmingham 48010
Birkelo, Carl H...4680 Dixie Hwy., Drayton Plains 48020
Blakeney, James R.........17 Utica Road, Pontiac 48058
Bloomberg, Sanford..............23023 Orchard Lk. Rd., Farmington 48024
Blue, Jane............19125 Hillcrest, Birmingham 48009
Boesky, Malcolm D..............26789 Woodward Ave., Huntington Wds. 48070
Boileau, Thornton I...............2075 E. 14 Mile Rd., Birmingham 48008
Bookmyer, Robt. M...............31815 Southfield Rd., Birmingham 48009
Boucher, Roman E.............4200 N. Woodward Ave., Royal Oak 48072
Bowers, Chas. L.....909 Woodward Ave., Pontiac 48053
Brady, Neal C.....3535 W. 13 Mile Rd., Royal Oak 48072
Brantley, Robt. E. (A)..............31260 E. Rutland, Birmingham 48009
Bronson, Wm. W.....................28119 John R St., Madison Heights 48071
Brown, Arnold L...........35 S. Johnson, Pontiac 48053
Bryan, Henry G.........22100 Coolidge, Oak Park 48237
Bryan, John B.....4045 W. 13 Mile Rd., Royal Oak 48072
Bryant, F. W.....3535 W. 13 Mile Rd., Royal Oak 48072
Budd, Alexander S. Z...............3511 Lakecrest Dr., Bloomfield Hills 48013
Buehrig, Robert............5790 M 15, Clarkston 48016
Bullard, R. W., Jr.............5790 M 15, Clarkston 48016
Bunto, William G.......5965 Orion Rd., Rochester 48063
Burger, John H...31815 Southfield Rd., Birmingham 48009
Burgess, Bruno.......29250 Longview St., Warren 48093
Burke, Chauncey G......35 W. Huron St., Pontiac 48058

Byberg, Robt. A...3535 W. 13 Mile Rd., Royal Oak 48072
Cabrera, G. P.....3535 W. 13 Mile Rd., Royal Oak 48072
Calhoun, Ethel T...707 Lakeview Ave., Birmingham 48009
Campbell, K. N..................1465 Cedar Bend Dr., Bloomfield Hills 48013
Campbell, Malcolm D. (R)......216 Washington Sq. Pl., Royal Oak 48067
Carioni, Juan C. (A)............Wm. Beaumont Hosp., Royal Oak 48072
Carlisle, Jos. D....3535 W. 13 Mile Rd., Royal Oak 48072
Carlson, Barbara F. (A)........St. Joseph Mercy Hosp., Pontiac 48053
Carpenter, G. B., Jr. 622 N. Woodward, Birmingham 48011
Carrow, Joyce M. (A)............1469 Highmoor Way, Bloomfield Hills 48013
Cashman, Edward F.....18715 Bretton Dr., Detroit 48823
Castedo, Nicanor F...............4189 Sunningdale Dr., Bloomfield Hills 48013
Cefai, Anthony F...........35 S. Johnson, Pontiac 48053
Cerkez, C. T...............35 S. Johnson, Pontiac 48053
Chandler, Douglas 1890 Southfield Rd., Birmingham 48009
Chandler, Jos. H.............309 Northland Med., Bldg., Southfield 48075
Cheng, James T. (R)...............30 Molly Stark Dr., Morristown, N.J. 07960
Cherup, Nicholas....Pontiac General Hosp., Pontiac 48053
Childers, Merle A...........320 Walnut, Rochester 48063
Chisa, Neldagae................26711 Woodward Ave., Huntington Wds. 48070
Clair, Alvin H. (M)
Clarke, Harriet A...........130 Seminole, Pontiac 48053
Cline, Alan L......4299 Roseberry, Drayton Plains 48020
Cobb, Thos. H.......880 Woodward Ave., Pontiac 48053
Cohen, Carl H.....909 Woodward, No. 110, Pontiac 48053
Cohen, Daniel H...20905 Greenfield Rd., Southfield 48075
Cohen, Jack J........17226 Adrian Rd., Southfield 48075
Cohen, Lewis..26602 Dundee Rd., Huntington Wds. 48070
Colakoglu, Celal..........2669 Coolidge, Berkley 48072
Collins, Edward F........35 W. Huron St., Pontiac 48058
Condon, Frank J...27725 Greenfield Rd., Southfield 48075
Conner, Edward D.................3856 S. Miller Way, Birmingham 48010
Conrad, Cecil D...............3027 N. Woodward Ave., Royal Oak 48072
Cooksey, Norton J. 3535 W. 13 Mile Rd., Royal Oak 48072
Cooley, Roy V...........318 S. Blvd. West, Pontiac 48053
Cooper, Edmond L.............4200 N. Woodward Ave., Royal Oak 48072
Cooper, Robt. S...............3027 N. Woodward Ave., Royal Oak 48072
Corrigan, K. E., Ph.D. (A)............300 Warren Court, Birmingham 48009
Coskey, Ralph J.........22100 Coolidge, Oak Park 48237
Coucke, Henry O..............1148 S. Woodward Ave., Royal Oak 48067
Counts, Robert W.......302 Walnut St., Rochester 48063
Crum, Roger E.............35 S. Johnson, Pontiac 48053
Cutler, Robert M.....909 Woodward Ave., Pontiac 48053
Cutler, Wm. M.....800 S. Adams Rd., Birmingham 48011
Dahlgren, Carl W..................3023 Orchard Lake, Keego Harbor 48033
Darling, C. G., Jr.....880 Woodward Ave., Pontiac 48053
Darnley, James D...............26711 Woodward Ave., Huntington Woods 48070
Dayton, Richard C...............427 W. University Dr., Rochester 48063
Deighton, Murray N...........23023 Orchard Lake Rd., Farmington 48024
Delaney, Malcolm J...........23023 Orchard Lake Rd., Farmington 48024
De Lawter, Hilbert H.............3535 W. 13 Mile Rd., Royal Oak 48072
Delevie, Jacob B..........640 Riker Bldg., Pontiac 48058
Deutsch, Wm. L...600 W. 11 Mile Rd., Royal Oak 48067
De Vito, H. Louis.......3115 Angelus Dr., Pontiac 48055
Dinger, David H...2561 Elizabeth Lk. Rd., Pontiac 48054
Dito, William R.....Pontiac General Hosp., Pontiac 48053
Dobski, Edwin J.....909 Woodward Ave., Pontiac 48053
Doerr, Louis E., Jr...1413 S. Washington, Royal Oak 48067
Donnelly, Wm. J...909 Woodward Avenue, Pontiac 48053
Dooley, William D......35 S. Johnson St., Pontiac 48053
Dorostkar, Massoud...............3262 Greenfield, B10, Royal Oak 48072
Dorsey, John M., Jr...............31815 Southfield Rd., Birmingham 48009
Drew, Dale R........909 Woodward Ave., Pontiac 48053
Drogowski, Edward J.....320 Walnut St., Rochester 48063
Duhamel, Peter A.....1055 Stellma Lane, Rochester 48063
Dunlap, Gregg L...............2870 Orchard Lake Rd., Keego Harbor 48033
Dunn, Lewis E......3924 Twelve Mile Rd., Berkley 48072
Durak, Gerald G...7105 Sherwood Dr., Birmingham 48010
Durocher, Normand E.......35 S. Johnson, Pontiac 48053
Dustin, Robt. W.....1314 W. Lincoln, Birmingham 48009
Ekelund, Clifford T. (L).........Pontiac General Hosp., Pontiac 48053
Elder, Edward E., Jr........1116 Voorheis, Pontiac 48053
Endress, Z. F., Jr...........35 S. Johnson, Pontiac 48053
Engel, John B. (R)...235 Linden Rd., Birmingham 48009
Ensroth, Jack F....1100 N. Woodward, Birmingham 48011
Esslinger, John O...............622 N. Woodward Ave., Birmingham 48011
Esslinger, Valentine..........3535 W. Thirteen Mi. Rd., Royal Oak 48072
Estanislao, A. P.............5790 M 15, Clarkston 48016
Evseeff, Geo. S.....3535 W. 13 Mile Rd., Royal Oak 48072
Farah, Jalil........3525 Brookside, Bloomfield Hills 48013
Fargher, Robert A...660 South Boulevard E., Pontiac 48053
Fidler, Wm. F.....1200 N. Telegraph Rd., Pontiac 48053
Fink, L. Jerome........500 W. Huron St., Pontiac 48053
Finkell, Lawrence J...4050 E. 12 Mile Rd., Warren 48092
Finkelstein, Lionel......577 Arlington, Birmingham 48009
Fishman, Gordon R. A...25721 Coolidge, Oak Park 48237
Fitzpatrick, F. J. (L).....92 Spokane Dr., Pontiac 48053
Flaharty, Wm. J. 25000 W. Ten Mile Rd., Southfield 48075
Flanagan, Paul..........4930 Big Oak Trail, Troy 48084
Fleurquin, A. G...................4415 Park Lane Ct., Bloomfield Hills 48013
Flick, John R.......120 W. Second St., Royal Oak 48067
Fox, Ralph M.......800 S. Adams Rd., Birmingham 48011
Franco, Napoleon.....Pontiac State Hosp., Pontiac 48053
Furlong, Harold A. (L)..35 S. Johnson Ave., Pontiac 48053
Fushman, John A..............4200 N. Woodward Ave., Royal Oak 48072
Gaba, Howard B...8245 Hendrie, Huntington Woods 48070
Gaber, Ben......10831 W. Ten Mile Rd., Oak Park 48237
Gadbaw, Jos. J...23607 Farmington Rd., Farmington 48024
Gaensbauer, F.............1965 N. Hammond Lake Rd., Pontiac 48053
Gagliardi, R. A.......880 Woodward Ave., Pontiac 48053
Galens, Gilbert J. 31815 Southfield Rd., Birmingham 48009
Galpin, Richard R...525 Southfield Rd., Birmingham 48009
Garber, Max J................23023 Orchard Lake Rd., Farmington 48024
Gariepy, Bernard F.......312 Park St., Royal Oak 48067
Garland, Donald M..........Pont. Motor, Glenwood Av., Pontiac 48053
Gates, Edward M...........35 S. Johnson, Pontiac 48053
Gates, Joann M.......65 S. Telegraph Rd., Pontiac 48053
Gatley, Leslie W.......445 W. Huron St., Pontiac 48053
Gause, Richard C. 31815 Southfield Rd., Birmingham 48009
Gayles, Carlos B. (A)..........473 Kuhn, Pontiac 48057
Gehringer, Norman F.......880 Woodward, Pontiac 48053
Geist, Edgar J., Jr.....1500 Walton Blvd., Rochester 48063
Gell, James W........35 S. Johnson Ave., Pontiac 48053
Gelstein, Lazaro......909 Woodward Ave., Pontiac 48053
Gelzayd, Eugene A...........15901 W. Nine Mile, #610, Southfield 48075
Gerber, George R. 310 W. University Dr., Rochester 48063
Gerls, Frank B. (L)...4425 Motorway Dr., Pontiac 48054
Gersabeck, Robert H..........4045 W. 13 Mile Road, Royal Oak 48072
Gibson, Wellington C....206 E. Commerce, Milford 48042
Gill, Matthew J..........1030 Riker Bldg., Pontiac 48058
Glen, Harold..........26684 Grand River, Detroit 48240
Goerner, Dorothy M. (A)..338 Pilgrim, Birmingham 48009
Goldberg, Howard S..............24777 Greenfield Rd., Southfield 48075
Goldstein, Herbert..22100 Coolidge Hwy., Oak Park 48237
Good, Wayne T...3306 Auburn Rd., Auburn Heights 48057
Goode, Norman J., Jr.....2000 Second Ave., Detroit 48226

Gordon, Clayton H...............1099 N. Cranbrook Rd., Birmingham 48009
Gradolph, Paul L...23338 Woodward Ave., Ferndale 48220
Gray, Murray H.........22100 Coolidge, Oak Park 48237
Green, J. Donald....217 Briggs Bldg., Birmingham 48011
Green, Ralph S.........24100 Stratford, Oak Park 48237
Green, Willard M...........35 S. Johnson, Pontiac 48053
Grekin, Thos. D...3535 W. 13 Mile Rd., Royal Oak 48072
Guillamondegui, O. M........3535 W. 13 Mile, No. 205, Royal Oak 48072
Gurol, Feridun....32316 Grand River, Farmington 48024
Gustafson, David C...............3535 W. 13 Mile Rd., Royal Oak 48072
Gustafson, Everette...........35 S. Johnson, Pontiac 48053
Gutterman, Meyer A..............25085 Coolidge Hwy., Oak Park 48237
Haanes, Merle A......909 Woodward Ave., Pontiac 48053
Hague, Gilbert W...................739 Westview Rd., Bloomfield Hills 48013
Halsted, Lee H................23023 Orchard Lake Rd., Farmington 48024
Hambalgo, George J.............26800 W. 13 Mile Rd., Franklin 48025
Hamburger, Joel I...20905 Greenfield Rd., Southfield 48075
Hamilton, Quentin P...20905 Greenfield, Southfield 48075
Han, Maolin....3358 Auburn Rd., Auburn Heights 48057
Hance, Joseph W.............306 Beaumont Med. Bldg., 3535 W. 13 Mile Rd., Royal Oak 48072
Harmon, Lewis G. 1775 E. 14 Mile Rd., Birmingham 48008
Harrold, John A.........534 Franklin Rd., Pontiac 48053
Harvey, Campbell (L)..P.O. Box 35, Orchard Lake 48033
Hasegawa, Carl M...............Beaumont Hosp., Path., Royal Oak 48072
Hassberger, John B.............620 N. Woodward Ave., Birmingham 48011
Hathaway, Wm. S...........433½ Main, Rochester 48063
Hayden, H. S., Ph.D. (A)............300 Warren Court, Birmingham 48009
Hecht, Manes S.....................26711 Woodward, Huntington Woods 48070
Heitsch, Joseph F. (A)..3860 Lonedale Rd., Pontiac 48057
Henderson, H. R...33750 Freedom Rd., Farmington 48024
Henderson, James E...909 Woodward Ave., Pontiac 48053
Henderson, Worth W...............1307 S. Washington, Royal Oak 48067
Hendren, Owen S...1408 Pontiac Bnk. Bldg., Pontiac 48058
Hendricks, Frank R................21701 W. 11 Mile Rd., Southfield 48075
Henry, Colonel R. (L)............125 W. Nine Mile Rd., Ferndale 48220
Hensley, Chas. B.....248 S. Broadway, Lake Orion 48035
Herman, Edward L........909 Woodward, Pontiac 48053
Hermes, Charles R.................4680 Dixie Highway, Drayton Plains 48020
Heyboer, Donald J...St. Joseph Mercy Hosp., Pontiac 48053
Hill, William E..........534 Franklin Rd., Pontiac 48053
Hoekman, Aben..1740 Hamilton Dr., Rte. 3, Pontiac 48053
Holmes, Keith M. 31815 Southfield Rd., Birmingham 48009
Hopkins, Melvin, Jr.....900 Baldwin Ave., Pontiac 48055
Hopkins, Wm. J..............17000 W. Eight Mile Rd., Southfield 48075
Howard, Marjorie E. (A).........Pontiac General Hosp., Pontiac 48053
Howell, Lynn E......909 Woodward Ave., Pontiac 48053
Hrushka, Myroslaw....Pontiac State Hosp., Pontiac 48053
Hsu, John J..............326 Riker Bldg., Pontiac 48058
Hubert, John R.......800 Woodward Ave., Pontiac 48053
Hymes, Alan C...3535 W. 13 Mile, 205, Royal Oak 48072
Ignatius, Aram A...1915 E. Nine Mile Rd., Ferndale 48220
Ingold, John A..........1080 Pilgrim, Birmingham 48009
Isaac, Herbert L...909 Woodward Ave., 115, Pontiac 48053
Isgut, Robert D.........28477 Hoover Rd., Warren 48093
Jackson, Philip J..........23480 Church, Oak Park 48237
Jacobi, Rodman C.......91 S. Washington, Oxford 48051
Jagnow, Nanette...525 Southfield Rd., Birmingham 48009
James, Robt. E., Jr...2561 Elizabeth Lk. Rd., Pontiac 48054
James, Thomas P.....1387 Chesterfield, Birmingham 48009
Jenkins, Henry L............161 State St., Pontiac 48053
Jennings, John A...21707 W. 11 Mile Rd., Southfield 48075
Johnson, J. Frederic...............23760 N. Woodward, Pleasant Ridge 48069
Johnson, James W.....2581 McClintock Rd., Pontiac 48053
Johnson, Robert H...............310 W. University Dr., Rochester 48063
Jones, Cyril D..............100 W. Hickory Grove Rd., Bloomfield Hills 48013
Joseph, Antoine L...4045 W. 13 Mile Rd., Royal Oak 48072
Joyce, John A.......413 Woodward Ave., Rochester 48063
Jury, Donald B. 1126 S. Woodward Ave., Royal Oak 48067
Kadian, George....20905 Greenfield Rd., Southfield 48075
Kamm, Robert L.......240 Daines St., Birmingham 48009
Karakuc, Raymond J..............Wm. Beaumont Hosp., Royal Oak 48072
Karca, N. Naci..6846 Cooley Lake Rd., Union Lake 48085
Katz, Sidney F...........17350 Dorset, Southfield 48075
Kaufman, Jacob M..............26711 Woodward Ave., Huntington Woods 48070
Kay, Sherman A.....1026 S. Washington, Royal Oak 48067
Kaylor, Marietta J. (A)........2435 Elizabeth Lake Rd., Pontiac 48053
Kazdan, Louis L. 13801 W. Nine Mile Rd., Oak Park 48237
Keeffe, Eugene J..............468 W. Williamsbury Rd., Birmingham 48010
Keith, Kelly............751 Chestnut, Birmingham 48008
Kemp, Felix J........880 Woodward Ave., Pontiac 48053
Kendrick, H. F., Jr.........35 S. Johnson, Pontiac 48053
Kennison, Warren S.......250 Martin, Birmingham 48011
Kerr, Edwin C.......32749 Franklin Rd., Franklin 48025
Ketchum, Jesse....120 W. 11 Mile Rd., Royal Oak 48068
Kettler, Hans J.....25160 Edgemont Rd., Southfield 48075
Khaneja, Satish C...140 Elizabeth Lake Rd., Pontiac 48053
Khodadadeh, B..................4252 Orchard Lake Rd., Orchard Lake 48033
Kinsley, George......909 Woodward Ave., Pontiac 48053
Klass, Arthur......1026 S. Washington, Royal Oak 48067
Klegman, Jerome H...........17000 W. Eight Mile Rd., Southfield 48075
Klein, Marvin E....15421 W. 9 Mile Rd., Oak Park 48237
Klewicki, H. A........22720 Woodward, Ferndale 48220
Knights, Edwin M., Jr...16001 9 Mile Rd., Southfield 48075
Knox, Richard S. 422 Washington Sq. Pl., Royal Oak 48067
Koehler, Wm. H...3535 W. 13 Mile Rd., Royal Oak 48072
Koltonow, Lawrence..........304 Northland Med. Bldg., Southfield 48075
Kornmesser, James G...........23023 Orchard Lake Rd., Farmington 48024
Korotney, Frank S. (A)...63 Charles Lane, Pontiac 48053
Kozlow, Clifford S...1201 Brookwood, Birmingham 48009
Kozlow, L. Ange............3535 W. Thirteen Mi. Rd., Royal Oak 48072
Kozonis, Michael C....880 Woodward Ave., Pontiac 48053
Kozora, Elmer J...17650 W. 12 Mile Rd., Southfield 48075
Krane, Mark..2335 S. Commerce Rd., Walled Lake 48088
Kresge, Bruce A.....1500 Walton Blvd., Rochester 48063
Krieger, Norman N.........402 Union St., Milford 48042
Krohn, Don R. 23023 Orchard Lake Rd., Farmington 48024
Kuhel, Eli H..........25415 Southfield, Southfield 48075
Kuhn, Anne C.....4203 W. 13 Mile Rd., Royal Oak 48072
Kuhn, Robt. E.....4203 W. 13 Mile Rd., Royal Oak 48072
Kurnetz, Ruben..10831 W. Ten Mile Rd., Oak Park 48237
La Ban, Myron M.......25101 Coolidge, Oak Park 48237
Labes, James....15101 W. McNichols Rd., Detroit 48235
Ladd, James E......31815 Southfield, Birmingham 48009
Lahti, Paul T.....3600 W. 13 Mile Rd., Royal Oak 48072
Lambert, Alvin G. 3535 W. 13 Mile, 505, Royal Oak 48072
Lanard, Francis W...31504 Sunset Dr., Birmingham 48010
Landers, James W...................1670 Keller Lane, Bloomfield Hills 48013
Landry, Roy A.........5770 S. Main St., Clarkston 48016
Larson, Alvin R......880 Woodward Ave., Pontiac 48053
Laux, Philip J., Jr...3027 N. Woodward, Royal Oak 48072
Lawson, James M.....2605 W. Grand Blvd., Detroit 48208
Laxa, Antonio A..........14 Edgelake, Union Lake 48085
Layman, Douglas C...............3535 W. 13 Mile Rd., Royal Oak 48072
Leach, Chas. A., Jr. 525 Southfield Rd., Birmingham 48009
Leahy, Etta Link (R)......1616 Wiltshire, Berkley 48072
Leichtman, R. R.............5770 M 15, Clarkston 48016
Lessien, Bruce T. 4045 W. Thirteen Mile, Royal Oak 48072

Levin, Murray B...7046 Cathedral Dr., Birmingham 48010
Levine, Bernard..................25835 Parkwood Dr., Huntington Woods 48070
Lewis, Sol M. (L).....541 W. Oakridge, Ferndale 48220
Lichtwardt, Harry E...............3535 W. 13 Mile Rd., Royal Oak 48072
Lichtwardt, John R...............3535 W. 13 Mile Rd., Royal Oak 48072
Lievois, Edward G.................289 Westbourne Dr., Birmingham 48010
Lilly, Richard J.....25336 Castlereigh, Farmington 48024
Limia, Antonio G.........24360 Kenosha, Oak Park 48237
Ling, T. W.....23607 Farmington Rd., Farmington 48024
Linn, Herman J...3601 W. 13 Mile Rd., Royal Oak 48072
Liu, Henry Y...16001 W. Nine Mile Rd., Southfield 48075
Longyear, Harold W..............3535 W. 13 Mile Rd., Royal Oak 48072
Lowell, James W.......2330 Fairway, Birmingham 48009
Lowery, Anthony J. (R)................8689 Golf Lane, Union Lake 48085
Lupovitch, Aaron........24661 Kenosha, Oak Park 48237
Lussos, A. S......2707 Bridle Rd., Bloomfield Hills 48013
Lutes, Byron B.............1232 Heyden, Pontiac 48054
Lyons, Robt. T.............35 S. Johnson, Pontiac 48053
Mackey, George S. 3601 W. 13 Mile Rd., Royal Oak 48072
Manz, Howard N.............23023 Orchard Lake Rd., Farmington 48024
Marcotte, Oliver J. (A).........25000 W. Ten Mile Rd., Southfield 48075
Margulis, R. Ralph...31815 Southfield, Birmingham 48009
Markley, John M...655 Ridge Rd., Bloomfield Hills 48013
Maroko, Simon W.........2416 Avondale, Pontiac 48053
Marra, John J..............35 S. Johnson, Pontiac 48053
Marsa, Percy S.....785 N. Lapeer Rd., Lake Orion 48035
Marshall, Joseph F. (A)........900 Woodward Avenue., Pontiac 48053
Martin, Donald W.....Pontiac State Hosp., Pontiac 48053
Martin, Francis A.........880 Woodward, Pontiac 48053
Mason, Robt. J. 618 N. Woodward Ave., Birmingham 48011
Mathura, G. R...........212 Riker Bldg., Pontiac 48058
Mayo, W. E. Barry............2338 N. Woodward Ave., Royal Oak 48073
Mayor, Raymond L.........35 S. Johnson, Pontiac 48053
McCain, French H..............628 N. Woodward Ave., Birmingham 48011
McCallon, Talmage D.............1307 S. Washington, Royal Oak 48067
McCandliss, D. H..........35 S. Johnson, Pontiac 48053
McConkie, James P...............2425 W. Lincoln Rd., Birmingham 48009
McDonald, Robert J............4200 N. Woodward Ave., Royal Oak 48072
McElroy, Wm. J., Jr...4520 Robinwood, Royal Oak 48073
McEvoy, Francis J.....1715 Crooks Rd., Royal Oak 48067
McHugh, James M. 20905 Greenfield Rd., Southfield 48075
McInerney, Thos. S......2026 Laurome, Royal Oak 48073
McIntyre, Jack B..........625 Purdy, Birmingham 48009
McLaughlin, J. H.................604 North Woodward, Birmingham 48011
McNeill, Howard H. (L)........225 W. Hickory Grove, Bloomfield Hills 48013
McPhee, Edward C........909 Woodward, Pontiac 48053
McWhirter, W. W..........302 Walnut, Rochester 48063
Megler, Mihael A...3710 S. Darlington, Birmingham 48010
Mehas, Constantine P..............1060 Trailwood Path, Birmingham 48010
Meisner, Harry E...24777 Greenfield Rd., Southfield 48075
Menge, Michael S.................31815 Southfield Rd., Birmingham 48009
Mercer, Frank A. (L)..............3032 Morningview, Birmingham 48010
Mevorah, Barukh L.....114 S. Lafayette, Royal Oak 48067
Milad, Anis A.......1111 N. Campbell, Royal Oak 48067
Miles, Franklin T...............4631 Shenandoah Ave., Allen Park 48101
Milgrom, Sidney 1229 S. Washington St., Royal Oak 48067
Miller, Arthur C...31723 Waltham Ct., Birmingham 48009
Miller, Hazen L. (L)........Box 247 A, Grayling 49738
Miller, Hubert........28554 Rivercrest, Southfield 48075
Miller, Irving M...............23023 Orchard Lake Rd., Farmington 48024
Miller, Sidney........200 Elm Street, Birmingham 49008
Mimura, James T.....31815 Southfield, Birmingham 48009
Moloney, James C.................5851 Farmington Rd., Orchard Lake 48033
Montani, Norberto J. (A)......William Beaumont Hosp., Royal Oak 48072
Mueller, Elmer J. 31815 Southfield Rd., Birmingham 48009
Mumby, Clinton J...............26789 Woodward Ave., Huntington Wds. 48070
Munson, Harry L...............2335 S. Commerce Rd., Walled Lake 48088
Murguz, Atalay M...1625 E. Fourth St., Royal Oak 48067
Murray, Kenneth W...31815 Southfield, Birmingham 48009
Musick, Gordon S...31327 W. Rutland, Birmingham 48009
Nalbandian, Robt. M................5145 Nob Hill Ct., Bloomfield Hills 48013
Nalepa, Eugene J.....880 Woodward Ave., Pontiac 48053
Nathanson, Milton L..............17000 W. 8 Mile Rd., Southfield 48075
Naz, John F........2826 Orange Grove, Waterford 48095
Neiswander, Paul L.......30001 Van Dyke, Warren 48090
Nessel, Jack H............880 Woodward, Pontiac 48053
Netzel, Robert J...................2700 Colonial Way, Bloomfield Hills 48013
Newby, Burns G.......20905 Greenfield, Southfield 48075
Newcomb, Arnold B...............19834 Riverside Dr., Birmingham 48009
Nichamin, Samuel J...............20905 Greenfield Rd., Southfield 48075
Nickerson, Ivey D...6245 Golfview Dr., Birmingham 48010
Niederluecke, D. C.........35 S. Johnson, Pontiac 48053
Nol, Edward A...........Pontiac St. Hosp., Pontiac 48053
Norzow, Alex J. (A) Pontiac General Hosp., Pontiac 48053
Nosanchuk, Jos. I...........35 S. Johnson, Pontiac 48053
Nunn, James W........751 Chestnut, Birmingham 48008
O'Donnell, C. H...23338 Woodward Ave., Ferndale 48220
Oliphant, Wm. W...785 N. Lapeer Rd., Lake Orion 48035
Olsen, Richard E.....900 Woodward Ave., Pontiac 48053
O'Neill, James A............5790 M 15, Clarkston 48016
Ormond, John K. (L)..909 Woodward Ave., Pontiac 48053
O'Sullivan, Girardin S...........26520 Willowgreen Way, Franklin 48025
Ott, Harold A...................Maternal & Child Hlth., 252 Hollister Bldg., Lansing 48933
Overy, Donald O.....880 Woodward Ave., Pontiac 48053
Packard, David C......5770 Highland Rd., Pontiac 48054
Page, Oliver W., Jr.........500 W. Huron, Pontiac 48053
Palmer, Hayden D. (L)..35 W. Huron St., Pontiac 48058
Paris, S. William..............23023 Orchard Lake Rd., Farmington 48024
Patel, Vishnubhai U. (A)........Pontiac General Hosp., Pontiac 48053
Patrick, Chas. I...4721 Dixie Hwy., Drayton Plains 48020
Patterson, J. C.....3535 W. 13 Mile Rd., Royal Oak 48072
Pauli, Theodore H. (R)............880 Woodward Ave., Pontiac 48053
Payton, Chas. F.......1719 Crooks Rd., Royal Oak 48067
Pear, Erwin G. 3027 N. Woodward Ave., Royal Oak 48072
Pearce, James F...3535 W. 13 Mile Rd., Royal Oak 48072
Peirce, Wm. H.....800 S. Adams Rd., Birmingham 48011
Pelletier, Chas. J.....1111 N. Campbell, Royal Oak 48067
Pensavecchia, J. S...........2680 Garland, Pontiac 48053
Pesaros, Panayotis..............648 N. Woodward Ave., Birmingham 48011
Pfeifer, John R...............15901 W. 9 Mile Rd., 600, Southfield 48075
Pitonyak, A. D.....St. Joseph Mercy Hosp., Pontiac 48053
Pool, Robert, Jr.....800 S. Adams Rd., Birmingham 48011
Porter, Kenneth F. 2709 Bradway Blvd., Birmingham 48010
Portnoy, Harold D.......445 W. Huron St., Pontiac 48053
Ports, Preston W...33108 Grand River, Farmington 48024
Poznanski, Elva O...............26789 Woodward Ave., Huntington Wds. 48070
Poznanski, W. A...............1100 N. Woodward Ave., Birmingham 48011
Proctor, Bruce.............3431 Baldwin, Pontiac 48055
Proctor, Conrad A...............3535 W. 13 Mile Road, Royal Oak 48072

Quarton, Albert E., Jr. 542 Pilgrim Rd., Birmingham 48009
Quinn, James R., Jr................2070 W. Valley Rd., Bloomfield Hills 48013
Rafani, Iraj..........3219 Belle Court, Royal Oak 48072
Ragins, Abner I.......909 Woodward Ave., Pontiac 48053
Ramirez, Ignacio O. (A)..............17380 Lincoln St., East Detroit 48021
Ramirez, Jaime (A)..............16001 W. 9 Mile Rd., Southfield 48075
Ramirez, Joaquin J......751 Chestnut, Birmingham 48008
Ranney, Kenneth I...............3535 W. 13 Mile Rd., Royal Oak 48072
Ravin, Mary A...............31237 Sleepy Hollow Ln., Birmingham 48010
Raynale, George P. (L)..............423 Tooting Lane, Birmingham 48009
Read, James A.....610 N. Woodward, Birmingham 48011
Reeh, Wm. R...................2335 S. Commerce Rd., Walled Lake 48088
Reid, Fred T. (L) 18450 Riverside Dr., Birmingham 48009
Reid, Robert E....3535 W. 13 Mile Rd., Royal Oak 48072
Reilly, Richard C.....880 Woodward Ave., Pontiac 48053
Relken, Richard C. (A)........St. Joseph Mercy Hosp., Pontiac 48053
Rendziperis, N. C.....118 W. Third St., Rochester 48063
Reutter, Carolyn..............17600 Northland Pk. Ct., Southfield 48075
Richard, Robert E.....1719 Crooks Rd., Royal Oak 48067
Richards, Wilson P.................3500 W. Maple Rd., Birmingham 48010
Richardson, Robt. P..................26711 Woodward, Huntington Woods 48070
Riggs, Harry L.........149 Franklin Blvd., Pontiac 48053
Riker, Aaron D. (L)......640 Riker Bldg., Pontiac 48058
Risk, Wm. R...................30671 Stephenson Hwy., Madison Heights 48071
Rivera, Eduardo..Wm. Beaumont Hosp., Royal Oak 48072
Roehm, Harold R. (L)..............319 Wabeek Bldg., Birmingham 48058
Romanik, John H.................31601 W. 13 Mile Rd., Farmington 48024
Romero, Lino A...............1880 S. Woodward Ave., Birmingham 48009
Rossin, Herbert W...20905 Greenfield Rd., Southfield 48075
Roth, Herbert J. (M)................31601 W. 13 Mile, Farmington 48024
Roumell, Theodore L...444 Walton Blvd., Rochester 48063
Rowley, Laurie G. (L) 2200 Telegraph Rd., Pontiac 48053
Ruesink, Donald E........127 Ferndale, Rochester 48063
Rupp, Edson C., Jr...............3535 W. 13 Mile Rd., Royal Oak 48072
Rush, Alva D., Jr.......391 Hamilton, Birmingham 48011
Ruskin, David S...20905 Greenfield Rd., Southfield 48075
Russell, Vincent P...3535 W. 13 Mile Rd., Royal Oak 48072
Rutzky, Julius....St. Joseph Mercy Hosp., Pontiac 48053
Ruva, Jos. J.......4463 Dixie Hwy., Drayton Plains 48020
Sadovsky, Vincent J...880 Woodward Ave., Pontiac 48053
St. John, Harold A. (L)..35 West Huron St., Pontiac 48058
Salisbury, C. S..........21580 Greenfield, Oak Park 48237
Samborski, Anne H. 32316 Grand River, Farmington 48024
Samet, Norman......1380 Dorchester, Birmingham 48008
Sanford, Glenn A...........35 S. Johnson, Pontiac 48053
Sansone, Thos J......909 Woodward Ave., Pontiac 48053
Satersmoen, Theodore....524 Riker Bldg., Pontiac 48058
Schaefer, Wm. C.........14001 Greenfield, Detroit 48227
Schirle, Jos. L., Jr.......1116 Voorheis Rd., Pontiac 48053
Schneider, Aaron....................26505 John R St., Madison Heights 48071
Schneyer, Jerome J............25000 W. Ten Mile Rd., Southfield 48075
Schoenfeld, Robt. J...800 S. Adams Rd., Birmingham 48011
Scholes, Danl. R...3535 W. 13 Mile Rd., Royal Oak 48072
Schrock, Marvin E.......35 S. Johnson St., Pontiac 48053
Schuneman, Howard A.........23760 Woodward Ave., Pleasant Ridge 48069
Schwartz, David................33120 W. Twelve Mile, Farmington 48024
Schweinsberg, Stephen (M).............USPHS Hosp., Staten Island, N.Y. 10304
Seaborn, Arthur J...............885 N. Woodward Ave., Birmingham 48009
Segula, Robt. L............35 S. Johnson, Pontiac 48053
Selman, Robert........500 W. Huron St., Pontiac 48053
Sempere, Chas. R...........35 S. Johnson, Pontiac 48053
Sewell, Geo. R.................411 West Ten Mile Rd., Pleasant Ridge 48069
Shadley, Maxwell L........94 Ottawa Dr., Pontiac 48053
Shea, James Joseph........35 S. Johnson, Pontiac 48053
Sheffield, Loren C..........35 S. Johnson, Pontiac 48053
Sheridan, F. Michael............1307 S. Washington St., Royal Oak 48067
Siegel, Marvin D.......445 W. Huron St., Pontiac 48053
Siegel, Peter.........880 Woodward Ave., Pontiac 48053
Siegel, Sheldon N. (M).......5956 Westchester Pk. Dr., College Park, Md. 20740
Siffring, Loren W.....427 W. University, Rochester 48063
Silberg, Joel J. (M)..................584 Martin Lane, Augusta, Ga. 30904
Silvani, John.........909 Woodward Ave., Pontiac 48053
Silver, Marvin D.........715 N. Main, Royal Oak 48067
Simpson, Edward K. (L).............2 Sunset Avenue, Chatham, Ont., Canada
Simpson, John R.........200 Elm St., Birmingham 48008
Smith, Carleton A.....880 Woodward Ave., Pontiac 48053
Smith, Donald S.........1010 Riker Bldg., Pontiac 48058
Smith, Geo. E.....3535 W. 13 Mile Rd., Royal Oak 48072
Somerville, Wm. J. 3535 W. 13 Mile Rd., Royal Oak 48072
Sosin, Allen..23023 Orchard Lake Rd., Farmington 48024
Spademan, Loren C. 484 Warren Court, Birmingham 48009
Spencer, Lloyd H.............1219 S. Washington Ave., Royal Oak 48067
Spiro, Henry J............27046 Pierce, Southfield 48075
Spoehr, Eugene L. 22832 Woodward Ave., Ferndale 48220
Spohn, Earle W. 324 Washington Sq. Pl., Royal Oak 48067
Stageman, John C.........909 Woodward, Pontiac 48053
Stanisavljevic, S...2338 Woodward Ave., Royal Oak 48073
Stanley, Wm. F.....1148 S. Woodward, Royal Oak 48067
Steffes, Everette M..............3345 Coolidge Highway, Berkley 48072
Stern, Sheldon D........802 Mutual Bldg., Detroit 48226
Stolpman, A. K.......640 Woodward, Birmingham 48011
Stolte, Jon L. (A)........36 Charles Lane, Pontiac 48053
Stone, David Q......Wixom Assembly Plant, P.O. Box 1, Wixom 48096
Stremler, Bernard J...1460 Chesterfield, Birmingham 48009
Stuecheli, Milton B. 1084 Willow Lane, Birmingham 48009
Sutton, Palmer E. (L)....222 Linden, Birmingham 48009
Swickle, Edward F...........17 S. Main, Clawson 48017
Swingle, Norman E...............1775 E 14 Mile Rd., Birmingham 48008
Szappanyos, Bela J.............3325 Burning Bush Rd., Birmingham 48010
Tan, Elaine Hartje....367 Old Perch Rd., Rochester 48063
Tan, King L.........367 Old Perch Rd., Rochester 48063
Tarpinian, Dick A...3535 W. 13 Mile Rd., Royal Oak 48072
Tauber, Abraham......500 W. Huron St., Pontiac 48053
Tavlan, Cemalettin..16001 W. 9 Mile Rd., Southfield 48075
Teich, Kenneth W.....900 Woodward Ave., Pontiac 48053
Teshima, John Y...22720 Woodward Ave., Ferndale 48220
Thorburn, Allan K....113 S. Franklin Blvd., Pontiac 48053
Tierney, Thomas D. 450 N. Woodward, Birmingham 48011
Torgerson, Thos. S......751 Chestnut, Birmingham 48008
Touma, Alfred.................26789 Woodward Ave., Huntington Wds. 48070
Trader, Kenneth N. 15901 W. 9 Mile Rd., Southfield 48075
Tregenza, Wm. K......20905 Greenfield, Southfield 48075
Tremblay, Raymond L.............2370 Walton Blvd., Rochester 48063
Trumpour, Donald J...2370 Walton Blvd., Rochester 48063
Tsiatalas, George..4045 W. 13 Mile Rd., Royal Oak 48072
Tubbs, Constance J...........15901 W. Nine Mile Rd., Southfield 48075
Tupper, Robert L..........86 Ottawa Dr., Pontiac 48053
Ulgenalp, Attila O.....909 Woodward Ave., Pontiac 48053
Ulveling, Robert A.......500 W. Huron St., Pontiac 48053
Underhill, Robert S..............26789 Woodward Ave., Huntington Woods 48070
Urwiller, K. L........909 Woodward Ave., Pontiac 48053
Van De Leuv, John H.............91 S. Washington St., Oxford 48051

Vanden Berg, Kenneth......35 S. Johnson, Pontiac 48053
Vander, Seymour A.................20905 Greenfield Rd., Southfield 48075
Van Zoeren, Jay J..................937 Rock Spring Rd., Bloomfield Hills 48013
Varbedian, Thos. G. 195 W. Brown St., Birmingham 48011
Vaught, Richard K.....2009 Crooks Rd., Royal Oak 48073
Veluswamy, V. P. (A)..Pontiac St. Hosp., Pontiac 48053
Von Valtier, Wm. F. (M)
Waehneldt, Niels R.........21730 Edna, Dearborn 48124
Wagner, Ruth E. (L)..315 Allen Avenue, Royal Oak 48073
Wake, Douglas L......1406 Woodsboro, Royal Oak 48067
Walden, Robert E...............1880 S. Woodward Ave., Birmingham 48011
Wallace, Donald B....880 Woodward Ave., Pontiac 48053
Wallack, Erwin N...............15660 W. Ten Mile Rd., Southfield 48075
Walser, Howard C....1300 Northlawn, Birmingham 48009
Wangner, William F................1401 S. Washington, Royal Oak 48067
Ward, W. Paul....3535 W. 13 Mile Rd., Royal Oak 48072
Warner, Fredk. H. O................3400 Sashabaw Rd., Drayton Plains 48020
Watson, Robert M. (M)
Watson, Thos. Y....640 N. Woodward, Birmingham 48011
Weaver, William F. 33750 Freedom Rd., Farmington 48024
Webber, Lynn F. (R)..461 Colonial Ct., Grosse Pte. 48236
Wechsler, Norman....880 Woodward Ave., Pontiac 48053
Wegrzyn, George C...1380 Brookwood, Birmingham 48009
Weingarten, Joel E.......18905 Carmona, Southfield 48075
Weintraub, G. S..............3535 W. 13 Mile Rd. 305, Royal Oak 48072
Weintraub, Rosalyn H. (A).........6990 Holiday Drive., Birmingham 48010
Weisman, Lawrence S.............909 East 12 Mile Rd., Madison Heights 48071
Weiss, Morris...................26339 Woodward Ave., Huntington Woods 48070
Wendling, Dieter..31815 Southfield Rd., Birmingham 48009
Wessels, Robt. R...302 Wabeek Bldg., Birmingham 48011
Westfall, Edwin J...3535 W. 13 Mile Rd., Royal Oak 48072
Westmaas, Wm. J.......................134 Jaikins Bldg., 1100 N. Woodward Ave., Birmingham 48011
White, Donal L.......31243 Cline Dr., Birmingham 48009
White, R. Hamilton 384 Hamilton Ave., Birmingham 48011
Wiant, John L.......258 Briggs Bldg., Birmingham 48011
Wigent, Ralph D...........Pont. Motor, Glenwood Ave., Pontiac 48053
Wilkinson, Wm. C.....880 Woodward Ave., Pontiac 48053
Williams, John P............35 S. Johnson, Pontiac 48053
Willis, Maurice E...........35 S. Johnson, Pontiac 48053
Winkler-Prins, V.................4256 Orchard Lk. Rd., Orchard Lake 48033
Wisniewski, E. M.......950 E. Maple, Birmingham 48011
Wolfe, Warren E. 6290 Wing Lake Rd., Birmingham 48010
Wood, Warren A., Jr. (M)............236 Fortress Ave., K. I. Sawyer AFB Mich. 49843
Woodward, Hanna L.............Pontiac General Hosp., Pontiac 48053
Woodward, Robert D...........1100 N. Woodward Ave., Birmingham 48011
Yesko, Veldora C...............26075 Woodward Ave., Huntington Wds. 48070
Ylvisaker, John R......880 Woodward Ave., Pontiac 48053
Youel, David B. (A)............Pontiac General Hosp., Pontiac 48053
Young, Arthur R. (L)....35 W. Huron St., Pontiac 48058
Yuzon, Ricardo A. (A)..........140 Elizabeth Lk. Rd., Pontiac 48053
Zimmerman, Walter J...............32340 Sylvan Lane, Birmingham 48009
Zinterhofer, J. J., Jr............27621 Santa Barbara Dr., Lathrup Village 48075
Zografov, Nikolas S...3648 Rockingham, Royal Oak 48072
Zujko, Alphonse J.........606 Riker Bldg., Pontiac 48058

OCEANA COUNTY MEDICAL SOCIETY (178)

Barker, V. D................22 N. State St., Hart 49420
Davis, Linford J............22 N. State St., Hart, 49420
Hasty, Willis A..............405 State St., Shelby 49455
Johnson, C. A....................Box 6, New Era 49446
Mullen, Warren R......................Pentwater 49449
Ratzlaff, Alvin J.
Robinson, Wm. G. (A)..............Memorial Hospital, Fatehgarh, U. P., India
Vrbanac, John J.............22 N. State St., Hart 49420

ONTONAGON COUNTY MEDICAL SOCIETY (182)

Archibald, Donald H.........Box 223, Ontonagon 49953
Beaghler, R. L.....Baraga Co. Mem. Hosp., L'Anse 49946
Lahti, Carl R....................R. 2, Ontonagon 49953
Pierpont, John............141 Maple, White Pine 49971
Strong, James P..........R. 1, Box 406, Ontonagon 49953
Strong, Wm. F.....103 W. Second Ave., Chico, Ca. 95926

OTTAWA COUNTY MEDICAL SOCIETY (186)

Albers, Robt..............601 Michigan, Holland 49423
Arendshorst, Wm.......601 Michigan Ave., Holland 49423
Beernink, Ernest H. (L)..............430 Duncan Ct., Grand Haven 49417
Bloemendaal, Dirk C.....351 N. Main St., Zeeland 49464
Bloemendal, W. B.....411 Woodlawn, Grand Haven 49417
Boersma, Vernon L.......121 W. 24th St., Holland 49423
Bonzelaar, Alvin..........144 West 26th, Holland 49423
Boone, Cornelius E. (L).............22 E. Central Ave., Zeeland 49464
Bulthuis, Jerry E......................Jamestown 49427
Chamness, James K.....121 W. 24th Street, Holland 49423
Clark, Nelson H.............17 W. 10 St., Holland 49423
Cook, Carl S............121 W. 24th St., Holland 49423
De Vries, Harold G.........30 E. 9th St., Holland 49423
De Vries, Peter J....321 Washington, Grand Haven 49417
De Witt, Donald E.......390 Fairhill Dr., Holland 49423
De Young, Fredk. W.................Spring Lake 49456
Dood, Arnold R.........598 Central Ave., Holland 49423
Dykema, Paul........788 Columbia Ave., Holland 49423
Dykstra, Jerome H..........601 Michigan, Holland 49423
Endean, Donald H......121 West 24th St., Holland 49423
Frieswyk, Melvin J.......241 E. Main St., Zeeland 49464
Gesink, Owen J.........492 Orchard Hill, Holland 49423
Groat, Frank L.....631 Franklin St., Grand Haven, 49417
Hager, Ralph.........................Hudsonville 49426
Hamelink, Marinus H.....700 W. 26th St., Holland 49423
Harms, Herman P.........17 W. 10th St., Holland 49423
Harvey, Dennis..........309 Terrill, Grand Haven 49417
Heard, Wm. (R)........504 Park St., Grand Haven 49417
Helbing, Edw. J., Jr.....17 W. 10th Street, Holland 49423
Henderson, Jack A...............1310 Wisconsin Ave., Grand Haven 49417
Hommerson, H. J.............3559 M40, Hamilton 49419
Kearney, Jos. B..........121 W. 24th St., Holland 49423
Kemme, Gerrit J................R. No. 3, Zeeland 49464
Kitchel, John H......414 Franklin St., Grand Haven 49417
Kitchel, Mary F. S...414 Franklin St., Grand Haven 49417
Kools, Wm. C...........194 W. 11th St., Holland 49423
Korpi, Steven......520 Ottawa Ave., Grand Haven 49417

Kuipers, Siebe................93 E. 29th, Holland 49423
Leppink, Richard A.........601 Michigan, Holland 49423
Mahaney, Robert C.......65 W. 22nd St., Holland 49423
McArthur, Peter A...1310 Wisconsin, Grand Haven 49417
Meeuwsen, Bernard....601 Michigan Ave., Holland 49423
Moerdyk, Wm. J. (L)....120 W. 14th St., Holland 49423
Nykamp, Russel R........111 E. Main St., Zeeland 49464
Post, J. Jay...........................Allendale 49401
Rottschaefer, Wm..........601 Michigan, Holland 49423
Rotz, Lloyd........575 Robbins Rd., Grand Haven 49417
Rypkema, Willard M...............22 South 2nd Street, Grand Haven 49417
Schaftenaar, R. H..........86 E. 28th St., Holland 49423
Schmidt, Frederick (M)....................6 Hancock, Ft. Leavenworth, Ks. 66027
Smit, George J.........601 Michigan Ave., Holland 49423
Smit, Henry (A)..c/o Dr. George Smit, 601 Michigan Ave., Holland 49423
Stobbelaar, Robt. H...1310 Wisconsin, Grand Haven 49417
Ten Have, Ralph.....1030 Orchard, Grand Haven 49417
Ten Pas, Henry W........293 W. 29th St., Holland 49423
Timmerman, Eugene C...............Coopersville 49404
Vander Berg, Edwin E.....17 W. 10th St., Holland 49423
Van Der Velde, Otto (L)...33 W. 8th St., Holland 49423
Vande Waa, Alfred J.....152 E. Cherry St., Zeeland 49464
Van Kolken, P. J........509 Franklin, Grand Haven 49417
Van Krimpen, Carl E...601 Michigan Ave., Holland 49423
Veenstra, Bernard M.................Grand Haven 49417
Ver Duin, John W...1618 Gladys Ave., Grand Haven 49417
Verkaik, Peter.......................Hudsonville 49426
Wang, Charles.........14 East 25th Street, Holland 49423
Wassink, Jerome H...........34 E. 33rd., Holland 49423
Wells, Kenneth N...119 W. Savidge St., Spring Lake 49456
Westrate, Warren K........17 W. 10th St., Holland 49423
Westrate, Wm., Sr. (L)....17 W. 10th St., Holland 49423
Westrate, Wm., Jr..........17 W. 10th St., Holland 49423
Winter, John K..............726 State St., Holland 49423
Winter, Wm. G., Jr.........630 State St., Holland 49423
Yff, John H............430 W. Lawrence, Zeeland 49464
Yonkman, Fredk. F...58 Pomeroy Rd., Madison, N.J. 07940

SAGINAW COUNTY MEDICAL SOCIETY (190)

Ackerman, Gerald L...124 S. Jefferson Ave., Saginaw 48607
Albers, Millard J...1227 N. Michigan Ave., Saginaw 48602
Anderson, Wm. K. (L).............845 St. Andrews Rd., Saginaw 48603
App, Robt. G.............3422 Davenport, Saginaw 48602
Arnas, George C...1600 N. Michigan Ave., Saginaw 48602
Averill, Walter C............2110 Morson, Saginaw 48602
Baleueua, Edgar P.........2 Chippewa Ct., Saginaw 48602
Barry, Jack L...........5670 Dixie Hwy., Saginaw 48601
Barry, Leroy C............705 Adams St., Saginaw 48602
Bass, Vernon V..........3322 Davenport, Saginaw 48602
Behme, C. Peter.........5160 Helga Dr., Saginaw 48603
Bellinger, Don H., D.D.S. (A)......By the Sea Box 365, Nokomis, Fla. 33555
Bergeon, Michael T..........2115 Bay St., Saginaw 48602
Bertrand, Marc G...1311 N. Michigan Ave., Saginaw 48602
Bishop, Harry M.........P. O. Box 129, Harrisville 48740
Bitner, Leland M...1811 N. Michigan Ave., Saginaw 48607
Blanchard, Gerald E.....GMC Chev. Mtr. Div., Box 1749, Saginaw 48605
Bow, William A.........4987 State Street, Saginaw 48603
Bradley, Edward............4444 State Rd., Apt. 214E, Saginaw 48603
Brender, Friedrich P................Frankenmuth 48734
Briggs, Gordon......350 W. Washington, Hemlock 48626
Bruggers, Laurence 1703 N. Michigan Ave., Saginaw 48602
Bullington, Bert M.........2000 Court St., Saginaw 48602
Burnett, Quinter M..........4385 Concord, Saginaw 48603
Busch, Frank J......1731 N. Michigan St., Saginaw 48602
Butler, Milton G...1600 N. Michigan Ave., Saginaw 48602
Cady, Donald J...........2002 Court St., Saginaw 48602
Cady, Fredk. J., Jr...402 S. Jefferson Ave., Saginaw 48607
Cady, Fredk. J. (L)..402 S. Jefferson Ave., Saginaw 48607
Cambridge, V. W......Potter at Jefferson, Saginaw 48607
Cameron, Allan K...1314 S. Jeffierson Ave., Saginaw 48601
Campbell, Lloyd A. (R)..............335 Brockway Pl., Saginaw 48602
Caumartin, Hugh T...........1537 S. Washington Ave., Saginaw 48601
Chisena, Peter R...........6221 Dixie, Bridgeport 48722
Choate, Frances S......1600 N. Michigan, Saginaw 48602
Cortopassi, Vital E..............324 S. Washington Ave., Saginaw 48607
Cory, Chas W.........1227 N. Michigan, Saginaw 48602
Cresswell, T. A........1236 N. Michigan, Saginaw 48602
Cullen, Geo. (A)....2529 N. Clinton St., Saginaw 48602
Curts, James H.....1205 N. Michigan Ave., Saginaw 48602
Davenport, Clyde P.........2110 Morson, Saginaw 48602
Derifield, R. S. (A).......25 Bretton Ct., Saginaw 48602
DeYoung, William A...............Central Laboratories, 1100 S. Washington, Saginaw 48601
Dowidat, Raymond W. (A)..608 Westfield, Saginaw 48602
Durman, Donald C. (R)...740 Belair Dr., Saginaw 48603
Ellis, George A.......16 E. Hannum Blvd., Saginaw 48602
Ely, Cecil W............1820 Janes Ave., Saginaw 48601
Ernst, Arthur R. (R)....Fieldmont, The Plains, Va. 22171
Esparza, Higinio S.....1100 S. Washington, Saginaw 48601
Farley, Albert W.......1013 N. Michigan, Saginaw 48602
Feeheley, Robert D...........3521 State, Saginaw 48602
Field, E. Malcolm.....1013 N. Michigan, Saginaw 48602
Finger, John E.......29 Brian Scott Place, Saginaw 48602
Fleschner, Thos. E. (R)...............Birch Run 48415
Forster, Kenneth J.........27 Benton Rd., Saginaw 48602
Galsterer, Edwin C...124 S. Jefferson Ave., Saginaw 48607
Gamon, Adam E., II......2004 Court St., Saginaw 48602
Gardner, Joe H.....815 N. Michigan Ave., Saginaw 48602
Gerard, Roy J...........2419 Mackinaw, Saginaw 48602
Gibbs, W. S.............3285 Schust Rd., Saginaw 48603
Gilmore, Robt. D.........234 W. Saginaw, Merrill 48637
Goldner, Richard D.....1024 N. Michigan, Saginaw 48602
Gomon, Louis D...1203 N. Michigan Ave., Saginaw 48602
Goodsell, John O.......1600 N. Michigan, Saginaw 48602
Goodsell, J. Orton, D.D.S. (A)..........1607 Cedar St., Saginaw 48601
Goodwin, J. E...........515 S. Jefferson, Saginaw 48607
Grant, Michael............101 Marcy, St. Charles 48655
Hand, Eugene A......126 N. Franklin St., Saginaw 48607
Harris, Geo. P.....Saginaw General Hosp., Saginaw 48602
Harvie, Lloyd G. (L)..........330 S. Washington Ave., Saginaw 48607
Heavenrich, Robt. M....1107 Gratiot Ave., Saginaw 48602
Heilbronn, Duane B....1703 N. Michigan, Saginaw 48602
Heinmiller, E. C...Saginaw Gen. Hospital, Saginaw 48602
Helmkamp, Herbert O.....333 S. Jefferson, Saginaw 48607
Hereza, Valeriano D......2125 Bay Street, Saginaw 48602
Hill, Victor, Jr.....1703 N. Michigan Ave., Saginaw 48602
Hines, Ronald G......St. Marys Hospital, Saginaw 48605
Hoban, Sean J.....1232 N. Michigan Ave., Saginaw 48602
Hubinger, H. L., D.D.S. (A)...501 2nd Natl. Bnk. Bldg., Saginaw
Hunt, Maurice E........5000 Maple St., Fairgrove 48733
Hyslop, Wm. T.........1610 Gratiot Ave., Saginaw 48602
Iizuka, Reiichi............77 Benton Rd., Saginaw 48602
Infante, A..............1931 E. Genesee, Saginaw 48601
James, John W.......1021 W. Genesee St., Saginaw 48607
Jardinieo, Robert..........303 S. Grange, Saginaw 48602
Jarvi, Rudolph M.......1107 Gratiot Ave., Saginaw 48602
Johnson, G. T. (A)........V.A. Hospital, Saginaw
Johnstone, Kermit T.....1050 Fisher Dr., Saginaw 48601
Jordan, Leo A........1524 E. Genesee St., Saginaw 48607
Kelly, Michael V...1811 N. Michigan Ave., Saginaw 48602
Kerr, Wm. B.........300 S. Michigan St., Saginaw 48602
Kershul, Victor W.................314 Graebner Bldg., 120 N. Michigan Ave., Saginaw 48602
Keyes, James T.......10222 Maple Rd., Birch Run 48415
Kiekham, Edward F.......705 Adams St., Saginaw 48602
Kleekamp, Herbert G. (R)......1776 S. Rogers Rd., R. 1, Clare 48617
Kleinschmidt, Earl E.....3625 Webber St., Saginaw 48601
Kolesar, Robt. C............1005 Gratiot, Saginaw 48602
Koueky, Charles J.........1375 Coolidge, Saginaw 48603
Kowals, Francis V..........Med. Dir. Chec. Ser. G.M.C., Saginaw 48603
Kretschmer, Thos. V.............1232 N. Michigan Ave., Saginaw 48602
Labsan, H. F.....1013 N. Michigan Ave., Saginaw 48602

Lassignal, Jules C...1600 N. Michigan Ave., Saginaw 48602
Ling, Kenneth C..........................Hemlock 48626
Lohr, Oliver W. (L)........614 Madison, Saginaw 48602
Lohr, Thos. O.....1135 N. Michigan Ave., Saginaw 48602
Love, Neil W.......505 W. Tuscola, Frankenmuth 48734
Lurie, Robt. I...2525 S. Washington Ave., Saginaw 48601
Mahaney, Thos. P.......3521 State Street, Saginaw 48602
Manning, John E...815 N. Michigan Ave., Saginaw 48602
Manning, John W., III........705 Adams, Saginaw 48602
Markey, Francis L......1600 N. Michigan, Saginaw 48602
Martin, Jack F.....1011 N. Michigan Ave., Saginaw 48602
Martzowka, Wm. P....415 W. Genesee St., Saginaw 48602
Mason, Wm. G.........1107 Gratiot Ave., Saginaw 48602
Matthews, Harry C..............1227 N. Michigan Ave., Saginaw 48602
Mayne, Harold E......2111 Marshall Ct., Saginaw 48602
McEwen, Wm. G..........1502 Court St., Saginaw 48602
Meyer, Henry J. (L)..6243 Dixie Hwy., Bridgeport 48722
Mikan, V. Robert......3900 Holland Rd., Saginaw 48601
Miller, Glenn F...........2224 Mershon, Saginaw 48602
Moeser, Ulrich.........1447 N. Harrison, Saginaw 48602
Moon, A. Raymond (L)..705 Sunset Lane, Cadillac 49601
Mooney, James C...1600 N. Michigan Ave., Saginaw 48602
Morgrette, Leonard J.....3424 Davenport, Saginaw 48602
Mudd, Richard D. (R)....1001 Hoyt St., Saginaw 48607
Mulhern, Donal T...2716 S. Jefferson Ave., Saginaw 48607
Murphy, Albert P...303 N. Michigan Ave., Saginaw 48602
Murphy, Richard T., D.D.S. (A)......1718 N. Michigan, Saginaw 48602
Murray, Morris J.........3424 Davenport, Saginaw 48602
Nelson, Oscar A.........3324 Davenport, Saginaw 48602
Noble, Paul R..........1447 N. Harrison, Saginaw 48602
Northway, Robt. O.....1811 N. Michigan, Saginaw 48602
Novy, Frank O. (L)..420 S. Jefferson Ave., Saginaw 48607
Olson, Carl P. (A)................122 Morningside Dr., Battle Creek 49015
Packer, James E......2235 Whitemore Pl., Saginaw 48602
Perea, Manuel M........6 Center Woods, Saginaw 48603
Phillips, Homer A......1600 N. Michigan, Saginaw 48602
Powers, Robt. F........1600 N. Michigan, Saginaw 48602
Prather, Perry E......1227 N. Mich. Ave., Saginaw 48602
Prinsell, Gustave G. (M).........Houghton, N.Y. 14774
Rank, J. Eugene.......1107 Gratiot Ave., Saginaw 48602
Reichman, Jos. J...........1455 Sheffield, Saginaw 48605
Reimers, Gerald F.......4046 Hess Street, Saginaw 48601
Rice, William T....1827 N. Michigan Ave., Saginaw 48602
Richards, Ned W..........3518 State St., Saginaw 48602
Richter, Harry J...........705 Adams St., Saginaw 48602
Roggen, Ivan J..........1227 N. Michigan, Saginaw 48602
Ruskin, Dave B.........1600 N. Michigan, Saginaw 48602
Ryan, Richard S...1581 S. Washington Ave., Saginaw 48601
Sample, John T. (L)........602 Rust St., Saginaw 48601
Sargent, Donald V. 1703 N. Michigan Ave., Saginaw 48602
Sarmiento, G. A...1600 N. Michigan Ave., Saginaw 48602
Schneider, A. J. N....509 S. Jefferson Ave., Saginaw 48607
Schultz, Frank R......243 W. Broad St., Chesaning 48616
Sharp, Martin C...1803 N. Michigan Ave., Saginaw 48602
Shek, John L...........803 N. Michigan, Saginaw 48602
Sheldon, Suel A..........124 S. Jefferson, Saginaw 48607
Sherman, John W.........403 S. Fayette, Saginaw 48602
Simms, Uca Frances......5707 Evergreen, Midland 48640
Skowronski, C. A.....1401 E. Genesee St., Saginaw 48607
Slade, Homer G....1520 N. Michigan Ave., Saginaw 48602
Spengler, Donald E., D.D.S. (A)......4481 Bradford Dr., Saginaw 48603
Stander, Aaron C..........1411 Court St., Saginaw 48602
Stewart, Geo. W...........1902 Janes St., Saginaw 48601
Sulfridge, Hugh L., Jr...........1011 N. Michigan Ave., Saginaw 48602
Talbot, Joseph E...1311 N. Michigan Ave., Saginaw 48602
Taylor, Robert E.......1447 N. Harrison, Saginaw 48602
Thompson, Arthur B......2144 Ottawa St., Saginaw 48602
Tiedke, Gunther E...120 N. Michigan Ave., Saginaw 48602
Toteff, Robert J..............2110 Morson, Saginaw 48602
Tramitz, Melvin E......711 Somerset Rd., Saginaw 48603
Tuttle, Terence K.........1109 Court St., Saginaw 48602
Underhill, Wm. G...........8 Five Oaks, Saginaw 48603
Villegas, Alfonso A...2111 Marshall Court, Saginaw 48602
Vincent, John H.....1911 Seminole Lane, Saginaw 48603
Vitu, Robert L..........703 W. Genesee, Saginaw 48602
Volk, Vladimir K............Saginaw Co. Hosp., Box 65, Saginaw 48605
Waite, Barry F............403 S. Fayette, Saginaw 48602
Walsh, Peter R...........331 S. Jefferson, Saginaw 48607
Webb, Lester E............1500 Gratiot, Saginaw 48602
Weiss, Arno W............3521 State St., Saginaw 48602
Westlund, Norman........3253 Congress, Saginaw 48602
Woomer, Donald F..............1227 N. Michigan Ave., Saginaw 48602
Wright, Edwin M......1311 N. Michigan, Saginaw 48602
Yntema, Stuart.....331 S. Jefferson Ave., Saginaw 48607
Young, John.............705 Cooper St., Saginaw 48602

ST. CLAIR COUNTY MEDICAL SOCIETY (194)

Bailey, Robt. S.......2425 Military St., Port Huron 48060
Banting, Kenneth C.............403 Peoples Bk. Bldg., Port Huron 48060
Barss, J. A............1209 Tenth St., Port Huron 48060
Battley, John C. S.........1216 6th St., Port Huron 48060
Beck, Frank K..........2902 Military, Port Huron 48060
Beer, Jos. F.......104 N. Riverside Ave., Saint Clair 48079
Bennett, Wm. G.............210 S. Main St., Yale 48097
Blatter, Erwin W.....3864 Gratiot Ave., Port Huron 48060
Borden, Chas. L.......236 Huron Ave., Port Huron 48060
Bottomley, Thos. H., Jr...1102 Sixth St., Port Huron 48060
Boughner, Walter H......325 Pleasant St., Algonac 48001
Bovee, Marion E. (L)..2208 Stone St., Port Huron 48060
Bowden, Wm. S......130 Washington, Marine City 48039
Bridge, Ezra V.......416 Edison Blvd., Port Huron 48060
Burke, Colman J..............411 Andrew Murphy Dr., Port Huron 48060
Cantwell, John D., Jr.....2425 Military, Port Huron 48060
Chafty, Mahmoud.......2425 Military, Port Huron 48060
Cleland, Wm. D., Jr. Medical Arts Bldg., Port Huron 48060
Clifford, Robt. P.....506 S. Riverside Dr., St. Clair 48079
Clyne, Benj. C..............103 N. Main St., Yale 48097
Coury, John J., Jr.......1209 Tenth St., Port Huron 48060
Davison, Wm. T......2425 Military St., Port Huron 48060
Dinnen, Wm. J., Jr.......2425 Military, Port Huron 48060
Douvas, Nicholas G......4200 Gratiot, Port Huron 48060
Dupuis, Jean Paul.....1502 Shumaker, Port Huron 48060
Escalera, Gustavo (A)..........1605 Fred Moore Hwy., St. Clair 48079
Fenton, Edwin H...906 St. Clair River Rd., Algonac 48001
Fitzgerald, E. W., Jr.....1102 Sixth St., Port Huron 48060
Franke, Armin T........2425 Military, Port Huron 48060
Fulton, Harold E., Jr...2425 Military St., Port Huron 48060
Gerrits, James F..........St. Clair Clinic, St. Clair 48079
Gholz, Anthony C...Medical Arts Bldg., Port Huron 48060
Gilmore, John R...317 Mich. Bank Bldg., Port Huron 48060
Gonzalez, Carlos F.....1605 Division Rd., St. Clair 48079
Hazledine, H. J.....4685 Lakeshore Rd., Port Huron 48060
Hislop, David M. C...4462 Gratiot Ave., Port Huron 48060
Hlivko, Alexander E..........1605 Fred W. Moore Hwy., St. Clair 48079
Hodgins, Thomas....3540 Lapeer Ave., Port Huron 48060
Holcomb, Russell J......140 S. Market, Marine City 48039
Hoyt, Chas. N..........1501 Krafft Rd., Port Huron 48060
Johnston, Thomas C...2425 Military St., Port Huron 48060
Kahn, Oscar B...........................Capac, 48014
Kirban, Harry N...5500 Lakeshore Rd., Port Huron 48060
Kirker, J. G........626 Busha Highway, Marysville 48040
Koch, Donald A.......2425 Military St., Port Huron 48060
Kostoff, Harold R.......310 Water St., Port Huron 48060
Lauridsen, James........621 River St., Port Huron 48060
Le Galley, K. B. (A).............6942 E. Exeter Blvd., Scottsdale, Az. 85251
Licker, Reuben R.....2425 Military St., Port Huron 48060
Ludwig, Claude A.....916 Seventh St., Port Huron 48060
Ludwig, Fredk. E.........916 7th St., Port Huron 48060
Lugg, Robt. M..........619 River St., Port Huron 48060
Mayhew, Harry E....613 N. Riverside Dr., St. Clair 48079
McColl, Duncan J. (L).............917 Prospect Place, Port Huron 48060
McCormick, Harry (A)..5075 24th Ave., Port Huron 48060
Meza, Pedro........1105 Sedgwick St., Port Huron 48060
Miller, John M......1010 Griswold St., Port Huron 48060
Mohney, Glenn E........1131 Erie St., Port Huron 48060

Morris, Alvin N.........621 River St., Port Huron 48060
Neruda, Fred..........640 N. Third St., St. Clair 48079
Novak, Walter S.....310 E. Water St., Port Huron 48060
Patterson, Dorsey W. (L).............622 Huron Ave., Port Huron 48060
Raftery, Michael.......2425 Military, Port Huron 48060
Rowe, Robt. E....108 McMorran Blvd., Port Huron 48060
Rutledge, John J. (A)..............2205 Standish Court, Port Huron 48060
Sabbagh, Michael I..........1605 Fred W. Moore Hwy., St. Clair 48079
Sanderson, Jos. L.........515 Pine St., Port Huron 48060
Schaefer, Waldo A...............302 Mich. Bank Bldg., Port Huron 48060
Serniak, John A.............104 S. Main St., Yale 48097
Shoudy, Elmore D.....902 Tenth Ave., Port Huron 48060
Sites, Edgar G.........1209 Tenth St., Port Huron 48060
Snider, James J.........2425 Military, Port Huron 48060
Tisdel, James H......310 E. Water St., Port Huron 48060
Tomsu, Glenn F.......310 E. Water St., Port Huron 48060
Townley, Chas. O......1209 Tenth St., Port Huron 48060
Treadgold, Douglas (A)..............1323 Military St., Port Huron 48060
Ulmer, Arthur H., Jr....1209 Tenth St., Port Huron 48060
Walker, Sidney C......1209 Tenth St., Port Huron 48060
Ware, J. Raleigh (R)....3107 24th St., Port Huron 48060
Webb, Gordon H......1322 N. River Rd., St. Clair 48079
Weckesser, W. C........1602 Military, Port Huron 48060
Wilhelm, Daniel J.....619 River Street, Port Huron 48060
Yost, Kenneth W.....1305 Gratiot Ave., Marysville 48040
Youngs, John A. .....718 Griswold St., Port Huron, 48060
Yull, Arthur B.........1209 Tenth St., Port Huron 48060

ST. JOSEPH COUNTY MEDICAL SOCIETY (198)

Berg, Lawrence A......106 E. Chicago Rd., Sturgis 49091
Bradley, D. E..............234 S. Main St., Colon 49040
Braham, Wilbur G.........111 S. Monroe, Sturgis 49091
Brothers, Paul L....1313 Rolling Ridge Ln., Sturgis 49091
Brunson, Allen E..........206 E. West St., Sturgis 49091
Dettman, Harold.........Maplecrest Plaza, Sturgis 49091
Evans, Robt. H..........111 S. Monroe St., Sturgis 49091
Fiegel, S. Albert..........111 S. Monroe, Sturgis 49091
Fortner, Roscoe J....137 Portage Ave., Three Rivers 49093
Gillespie, Eleanor M...............Rt. 2, Sturgis 49091
Hill, Robert V...............1500 N. Main St., Box 171, Three Rivers 49093
Jacobowitz, John M..................Lincoln at Millard, Three Rivers 49093
Lepard, Olin L........Knollwood Dr., R. 1, Sturgis 49091
McCullough, Hugh......111 S. Monroe St., Sturgis 49091
O'Dell, Charles W.....117 Spring St., Three Rivers 49093
O'Dell, John H., Jr..................Three Rivers 49093
Olney, Frank (A)....................Centerville 49032
Pennington, Harry C.................118 S. Kalamazoo, White Pigeon 49099
Penzotti, Stanley C.....117 Spring St., Three Rivers 49093
Porter, Clark G..........226 East St., Three Rivers 49093
Schimnoski, D. R..............Three Rivers Med. Clnc., Three Rivers 49093
Shaw, Geo. D.........117 Spring St., Three Rivers 49093
Sheldon, John P...........206 E. West St., Sturgis 49091
Smith, Robt. D.........................Colon 49040
Weisheit, H. R...................Route 1, Sturgis 49091
Zimont, Chas. R......................Constantine 49042
Zimont, Raymond D.................Constantine 49042

SANILAC COUNTY MEDICAL SOCIETY (202)

Cripps, James R........................Marlette 48453
Duvall, Dorothy......817 Patterson Ave., Bay City 48706
Ford, Frances A. (L)............2683 S. Lakeshore Rd., Applegate 48401
Gift, Weldon A. (L)...................Marlette 48453
Groat, Gerald........................Deckerville 48427
Hart, Robt. K. (L)....................Croswell 48422
Jayson, Michael H......2764 Lorraine St., Marlette 48453
McCrea, John W.......................Marlette 48453
McGunegle, Keate T...................Sandusky 48471
Muir, Neil...........................Croswell 48422
Seager, M. Cole......................Brown City 48416
Smith, Duane E.......................Brown City 48416
Tweedie, G. Evans.....................Sandusky 48471
Tweedie, S. Martin....................Sandusky 48471
Webster, J. C. (L)....................Marlette 48453
Winfield, Raymond J........3014 Main St., Marlette 48453

SHIAWASSEE COUNTY MEDICAL SOCIETY (206)

Arnold, Alfred L., Jr. (L).............R. 1, Ovid 48866
Austin, Eugene S............1260 Ada St., Owosso 48867
Bach, Norman F..........113 E. Williams, Owosso 48867
Bjarnesen, Walter (A)................7518 Hamlet St., North Springfield, Va. 22151
Brown, Richard C.....113 E. Williams St., Owosso 48867
Buzzard, Walter D....................Chesaning 48616
Cameron, Richard R.....701 W. Oliver St., Owosso 48867
Chipman, Elwood M. (R)..........502 W. Williams St., Owosso 48867
Clifford, Robert..........Matthews Bldg., Owosso 48867
Foerster, Alfred W.....113 E. Williams St., Owosso 48867
Ford, Wm. J. A., Jr....113 E. Williams St., Owosso 48867
Forsyth, Henry T.....137 S. Saginaw St., Chesaning 48616
Graves, James H.........511 W. Main St., Owosso 48867
Gurden, Elizabeth A. L.............113 E. Williams St., Owosso 48867
Harroun, John E...........224 N. Ball St., Owosso 48867
Harroun, R. V.............224 N. Ball St., Owosso 48867
Hofstra, John..........................Owosso 48867
Hoshal, Verne L..........104 W. Clinton, Durand 48429
Kennedy, John J........1626 N. Chipman, Owosso 48867
Lipsey, Donald.........................Durand 48429
MacGregor, John F.....113 E. Williams St., Owosso 48867
McGeehan, J. S...........Matthews Bldg., Owosso 48867
McKnight, Edwin R..............320 N. Washington St., Owosso 48867
Merz, Walter L...............307 N. Ball, Owosso 48867
Moore, Phillip J..........221 E. North St., Owosso 48867
Morovitz, John E.........113 E. Williams, Owosso 48867
Park, James H............812 Bradley St., Owosso 48867
Phillips, Rolland..........Matthews Bldg., Owosso 48867
Richards, Chester J. (L) 101 E. Monroe St., Durand 48429
Roty, Robert L. (M)......Matthews Bldg., Owosso 48867
Sahlmark, Jos. F..........812 Bradley St., Owosso 48867
Sauer, Peter.............113 E. Williams, Owosso 48867
Shepherd, Walter F. (R)..............921 Coolidge Rd., Lansing 48912
Trick, O. L. (A)...Duke University, Durham, N.C. 27706
Weinkauf, Wm. F. (L)................Corunna 48817
Weston, Claude L. (L)....Matthews Bldg., Owosso 48867
Wickstrom, Geo. B.........529 Clark Ave., Owosso 48867

TUSCOLA COUNTY MEDICAL SOCIETY (210)

Anderson, Norma.............206 Ellington, Caro 48723
Ballard, James H.......................Cass City 48726
Chapin, Maurice H...................Millington 48746
Cole, Versa V..................Lock Box A, Caro 48723
Dickerson, Willard W.......Caro State Hosp., Caro 48723
Donahoe, Harold T.........4674 Hill St., Cass City 48726
Elmendorf, E. N., II.......................Vassar 48768
Flett, Richard O......................Millington 48746
Gokcora, Nurettin B..........Caro St. Hosp., Caro 48723
Gugino, George J. (M).......1941 Gate St., Reese 48757

Howlett, Robt. R...........624 W. Frank St., Caro 48723
Kovacs, Geza.............861 Gilford Road, Caro 48723
Merrill, Elmer H............506 Gilford Rd., Caro 48723
Miles, Edward J.........................Caro 48723
Nigg, Herbert L.........................Caro 48723
Savage, Lloyd L. (L).............5208 Port Austin Rd., Caseville 48725
Swanson, Ewald C...........220 N. Main, Vassar 48768
Urban, Mitchell...........Caro State Hosp., Caro 48723
Von Renner, Otto (L)........P. O. Box 222, Reese 48757

VAN BUREN COUNTY MEDICAL SOCIETY (214)

Boothby, Carl F.......................Hartford 49057
Boothby, Fredk. M....................Lawrence 49064
Boyd, Wayne R........Route 4, Box 307, Paw Paw 49079
Cooper, Jos. E.........417 W. Monroe St., Bangor 49013
Davis, James M........424 Huron St., South Haven 49090
Diephuis, Bert........511 Huron St., South Haven 49090
Dillon, Thos. J. (A)....240 S. Eudora, Denver, Co. 80220
Gano, Avison............417 Monroe St., Bangor 49013
Genstler, Paul...............309 Upper Serangoon Rd., Singapore 13, Malaya
Itzen, John F..........P.O. Box 485, South Haven 49090
Johnson, Harold C. A. (A)..........Lake View Terrace, Paw Paw 49079
Kleber, John A........365 Broadway, South Haven 49090
Lawther, John............P.O. Box 191, Hartford 49057
Loomis, Frank J......................Paw Paw 49079
Lukaszek, Henry J. 77 N. Shore Drive, South Haven 49090
McFadden, Roscoe I...............Bloomingdale 49026
McManus, T. M..........Center Bldg., Paw Paw 49079
Millard, David......................Paw Paw 49079
Morgan, Dale K......403 Phoenix St., South Haven 49090
Parks, Arthur E.........................Lawton 49065
Spalding, R. W..............P.O. Box 280, Gobles 49055
Stagg, Adelbert L.........9 N. Maple St., Hartford 49057
Stagg, G. Lee.................Box 307, Hartford 49057
Stagg, Ruth E. A................Box 38, Hartford 49057
Sundin, Paul W. (A)...................Decatur 49045
Ten Houten, Charles..................Paw Paw 49079
Terwilliger, Edwin H...P.O. Box 110, South Haven 49090
Urist, Martin J.............Route 5, South Haven 49090
Witte, David B............Route 3, South Haven 49090
Young, Wm. R. (L)....................Lawton 49065

WASHTENAW COUNTY MEDICAL SOCIETY (218)

Alexander, Don K. (A)..............712 Thomas Court, Ann Arbor 48103
Alford, Barry H............385 N. Mill., Plymouth 48170
Allen, Richard J.....University Hospital, Ann Arbor 48104
Anderson, David G........2490 Adare, Ann Arbor 48104
Anderson, Gerhard D. (A)..2929 Verle, Ann Arbor 48104
Anderson, Robt. E.....2136 S. Seventh, Ann Arbor 48103
Armstrong, Mac J...31115 Huntley Sq., Birmingham
Atchison, Russell M.....501 W. Dunlap, Northville 48167
Ause, Robert G..........1821 Sheridan, Ann Arbor 48104
Badgley, Carl E. (L)..1313 E. Ann St., Ann Arbor 48104
Bailey, Robt. W.......University Hosp., Ann Arbor 48104
Baird, Walter M...2558 Old Boston Ct., Ann Arbor 48104
Bandera, Emily A.......P.O. Box 1047, Ann Arbor 48106
Bandera, Jaroslav M...........4200 E. Huron River Dr., Ann Arbor 48104
Banghart, Norman L..............1950 Manchester Rd., Ann Arbor 48104
Barker, Paul S. (R)......Box 87, Bonnots Mill, Mo. 65016
Barlow, R. Craig.....326 N. Ingalls St., Ann Arbor 48104
Barron, Walter L........326 N. Ingalls St., Ann Arbor 48104
Barry, Alexander, Ph.D. (A)....Med. Sc. Bldg., U. of M., Ann Arbor 48104
Barss, Wm. A...........525 W. Cross St., Ypsilanti 48197
Bartholomew, Lee E...........4633 Kresge Bldg., U. M., Ann Arbor 48104
Bass, Thos. J............201 S. Hamilton, Ypsilanti 48197
Bassow, Paul H........St. Joseph Hosp., Ann Arbor 48104
Bauer, Gerhard H...2015 Manchester Rd., Ann Arbor 48104
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Sweet, Robt. B........1313 E. Ann St., Ann Arbor 48104
Taylor, Fulton B..........1107 S. Harris, Ypsilanti 48197
Taylor, Wm. B..........326 N. Ingalls, Ann Arbor 48104
Teed, R. Wallace..........215 S. Main, Ann Arbor 48108
Thieme, E. Thurston...........St. Joseph Mercy Hosp., Ann Arbor 48104
Thompson, A. S.....2432 Dorchester Rd., Ann Arbor 48104
Thompson, George R....1400 Traver St., Ann Arbor 48105
Threatt, Barbara A. (A).............44652 Ecorse Rd., Belleville 48111
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Tiziani, Joseph J.............3412 Brassow, Saline 48176
Tourtellotte, W. W.....University Hosp., Ann Arbor 48104
Towsley, Harry A...Dept. of P.G. Medicine, Univ. of Mich., Ann Arbor 48104
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Vander Yacht, W. C.........203 Russell St., Saline 48176
Van Duzen, Verne L. (L)....131 E. Miller, Milan 48160
Vanhouten, Wiecher H...............Univ. Medical Ctr., Ann Arbor 48104
Van Reesema, F. S.....1608 Kirtland Dr., Ann Arbor 48103
Vanselow, Neal A.......1532 Warwick, Ann Arbor 48104
Waggoner, R. Walter..3333 Geddes Rd., Ann Arbor 48105
Waggoner, R. W., Jr. (A) 1421 Barnard, Ann Arbor 48103
Waldron, Alexander M...309 N. Ingalls, Ann Arbor 48104
Waldyke, Jerry L.........109 N. Main St., Chelsea 48118
Wallner, Julius M......1313 E. Ann St., Ann Arbor 48104
Wamsteker, E. F...3415 Robinwood Dr., Ann Arbor 48103
Watkins, Richard D........4140 Miller, Ann Arbor 48103
Watson, Ernest H. University Med. Cen., Ann Arbor 48104
Wegman, Myron E...............University of Michigan, Ann Arbor 48104
Weisman, Raoul L.....32 N. Washington, Ypsilanti 48197
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Westover, Chas J...............982 W. Ann Arbor Trail, Plymouth 48170
Wetterstroem, Robt. G...........46376 W. 7 Mile Road., Northville 48167
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White, Richard L.....820 Edgewood Pl., Ann Arbor 48103
Whitehouse, W. M...1313 E. Ann Street, Ann Arbor 48104
Whowell, Marianne..1805 Ivywood Dr., Ann Arbor 48103
Wicht, Paul J.............27 S. Prospect, Ypsilanti 48197
Williams, Howard R...............1950 Manchester Rd., Ann Arbor 48104
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Barnett, Robert F.........Mercy Hospital, Cadillac 49601
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Cardinal, Thos H..........212 S. Simons, Cadillac 49601
Daugharty, Robt. V.......107 N. Mitchell, Cadillac 49601
Garber, Lawrence O......222 Howard St., Cadillac 49601
Inman, John C.......................Lake City 49651
Moon, Wm. W..............826 Oak St., Cadillac 49601
Pierce, Robert E......1430 Sunnyside Dr., Cadillac 49601

Posthuma, Millard..........828 Oak St., Cadillac 49601
Richmond, Thomas F...604 Lake Shore Dr., Cadillac 49601
Sanderson, James M..........512 Chapin, Cadillac 49601
Seger, Dean W......................Lake City 49651
Tornberg, G. C. (R)........R. 1, Box 150, Cadillac 49601
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Abbassian, A............970 Fisher Bldg., Detroit 48202
Abbott, James A.........1012 Kales Bldg., Detroit 48226
Aben, Gerald J..........1075 Fisher Bldg., Detroit 48202
Aboassaly, Michel...1059 Bedford, Grosse Pte. Park 48236
Aboulafia, Elie D.........18241 Greenfield, Detroit 48235
Abraham, Jos. P......2799 W. Grand Blvd., Detroit 48202
Acosta, Julio B...........25447 Plymouth, Detroit 48239
Adamian, Cerald D........611 Kales Bldg., Detroit 48226
Adams, James R...........3815 Pelham, Dearborn 48124
Adams, Vincent B.....19641 Mack Ave., Grosse Pte. 48236
Adamski, Arthur............19666 Conant, Detroit 48234
Adelson, Seymour S.....18400 Schaefer Rd., Detroit 48235
Adelson, Sidney L.......16221 Schoolcraft, Detroit 48227
Adler, Morton W..............2860 Clark, Detroit 48232
Adler, Sidney........3011 W. Grand Blvd., Detroit 48202
Agnew, Geo. H......3011 W. Grand Blvd., Detroit 48202
Agnew, Richard C........564 Fisher Bldg., Detroit 48202
Agnone, Eugene J.....1420 St. Antoine St., Detroit 48226
Agnone, Peter M......1420 St. Antoine St., Detroit 48226
Aiuto, Jas. J.........660 Cadieux Rd., Crosse Pte. 48230
Ajlouni, Issa S.............Chrysler Corp., Detroit 48226
Ajluni, Roger M.....33521 W. 6 Mile Rd., Livonia 48152
Akroyd, Cecil..........16551 W. Warren, Detroit 48228
Alban, Emil J., Jr.......7940 Allen Rd., Allen Park 48101
Albrecht, Albert J.........4407 Roemer, Dearborn 48126
Alexander, Allen..........18881 Hilton, Southfield 48075
Alexander, Eugene J.......24140 Wilson, Dearborn 48128
Alexander, G. D....25799 Lathrup Blvd., Southfield 48075
Alexander, L. C..........1204 Kales Bldg., Detroit 48226
Alfonso, Manuel A...20825 Mack, Crosse Pte. Woods 48236
Alford, Elvis S.............105 Main St., Belleville 48111
Allaben, Robert D.............18255 W. McNichols Rd., Detroit 48219
Allen, John V.....1336 Southfield Rd., Lincoln Park 48146
Allison, Herbert C. (L)....383 Fisher Rd., Detroit 48236
Alpern, E. Bryce......2840 W. 7 Mile Rd., Detroit 48221
Alpiner, Sam......2850 E. Seven Mile Rd., Detroit 48234
Altman, Jules....14633 E. Seven Mile Rd., Detroit 48205
Altman, Raphael..17000 West 8 Mile Rd., Southfield 48075
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Alvarez, Hernan, Jr......Henry Ford Hosp., Detroit 48202
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Arcari, Frederico A.......771 Fisher Bldg., Detroit 48202
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Arehart, Burke W......340 Eastland Bldg., Detroit 48236
Arends, Norman J...302 Eastland Prof. Bldg., Detroit 48236
Arent, John G.....24251 W. McNichols Rd., Detroit 48219
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Arminski, Thos. C.......1066 Fisher Bldg., Detroit 48202
Armstrong, Arthur G. (L).........3001 W. Grand Blvd., Detroit 48202
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Arnold, Effie E. (L).......16520 Oakfield, Detroit 48235
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Atler, Lawrence R..........681 W. Forest, Detroit 48201
Auble, Max E.........20905 Greenfield, Southfield 48075
August, Harry E......26339 Woodward, Royal Oak 48072
Austin, Donald C....320 Professional Bldg., Detroit 48201
Austin, Shirley.......5224 St. Antoine St., Detroit 48202
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Avrin, Ira........24777 Greenfield Rd., Southfield 48075
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Axelrod, Mildred A.............3535 W. 13 Mile Rd. 305, Royal Oak 48072
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Bacher, Burton J.........1015 Kales Bldg., Detroit 48226
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Bacon, Vinton A. (L).....18400 Livernois, Detroit 48221
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Baer, Walter.........16321 Mack Avenue, Detroit 48224
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Balian, John V.........Henry Ford Hosp., Detroit 48202
Ballard, Donald R........20520 Audette, Dearborn 48124
Balog, Janos.............2300 Oak St., Wyandotte 48192
Balow, Ross M.........18700 Meyers Rd., Detroit 48235
Balser, Chas. W. (L).......13931 Gratiot, Detroit 48205
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Banish, Gerald........23100 Cherry Hill, Dearborn 48124
Banks, Thomas L...18597 W. 10 Mile Rd., Southfield 48075
Barak, Lewis R...7448 W. Seven Mile Rd., Detroit 48221
Barak, Stuart...........18241 Greenfield, Detroit 48235
Baran, Alphonse W...15841 W. Warren St., Detroit 48228
Barbaglia, Louis C..........16378 Harper, Detroit 48224
Barber, Radivoj R.......864 S. Main St., Plymouth 48170
Bardenstein, M. B...17000 W. 8 Mile Rd., Southfield 48075
Barefield, Alwin S.....10244 W. 7 Mile Rd., Detroit 48221
Barenholtz, Benj.......20905 Greenfield, Southfield 48075
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Barlow, Myron..........18050 Mack, Crosse Pte. 48236
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Barnett, Morton....1527 David Stott Bldg., Detroit 48226
Barone, C. Gerald....15231 W. 7 Mile Rd., Detroit 48235

Barrett, C. D., Jr....316 City County Bldg., Detroit 48226
Barrett, Raymond J..........18280 Fairfield, Detroit 48221
Barrett, Wyman D. (L)..........1553 Woodward Ave., Detroit 48226
Barron, James.....2535 Amberly Rd., Birmingham 48010
Barron, Wm. H.........14938 Livernois St., Detroit 48238
Barsky, David............100 Oak St., Wyandotte 48192
Barton, Jos. R. (L)......19619 W. Warren, Detroit 48228
Baruch, Robert J........18737 Hilton Rd., Southfield 48075
Basel, Arthur R. (A)..951 E. Lafayette St., Detroit 48207
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Battle, John M.......6904 Charlesworth, Dearborn 48127
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Bauer, Lester E. (A)..................4 Woodside Pk., Pleasant Ridge 48069
Bauer, Ralph E.......Henry Ford Hospital, Detroit 48202
Bauer, Raymond B........Harper Hospital, Detroit 48201
Baugh, Evelyn F...........9191 Whittier, Detroit 48224
Baugh, Richard H...24216 Michigan Ave., Dearborn 48124
Baugh, Robert F...........9191 Whittier, Detroit 48224
Baumer, Moe...............10 Peterboro, Detroit 48201
Baumgarten, Elden C. (L)........1062 Lochmoor Blvd., Grosse Pte. Woods 48236
Baumgarten, Thos. W..................20867 Mack Ave., Grosse Pte. 48236
Bautista, Joaquin P......20503 Dequinder, Detroit 48234
Baxter, Seymour..........19925 Livernois, Detroit 48221
Bayles, John G.........14411 E. Jefferson, Detroit 48215
Bazil, Gilbert M...........14200 Puritan, Detroit 48227
Beach, Watson (L)...20825 Mack Avenue, Detroit 48236
Beam, A. Duane......................20160 Mack Ave., Grosse Pte. Woods 48236
Beamer, Geo. D....14853 Michigan Ave., Dearborn 48126
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Becker, Abraham....3790 Woodward Ave., Detroit 48201
Beekett, Peter G. S....951 E. Lafayette St., Detroit 48207
Beckett, Victoria L. (A)....................1420 Anita, Grosse Pte. Woods 48236
Becklein, Clarence L.............14351 E. Warren Ave., Detroit 48215
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Bedell, Archie A.........15545 Mack Ave., Detroit 48224
Bedwell, Wm. L.........1211 Kales Bldg., Detroit 48226
Beebe, Willard E...14801 Southfield Rd., Allen Park 48101
Beekhuis, G. Jan......1326 St. Antoine St., Detroit 48226
Beeuwkes, L. E.....13014 Mackenzie Ave., Detroit 48228
Behan, Robt. C........1 Woodward Ave., Detroit 48226
Beitman, Max R..........510 Kales Bldg., Detroit 48226
Beizai, Khosrow........22101 Moross Rd., Detroit 48236
Belanger, W. Geo..........1041 Harvard, Detroit 48230
Belden, Darwin F...........2424 Puritan, Detroit 48238
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Bende, Sandor F........15863 Garfield, Allen Park 48101
Beninson, Joseph........Henry Ford Hosp., Detroit 48202
Bennett, Germany E.......1446 E. Forest, Detroit 48207
Bennett, Harry B...........7015 Intevale, Detroit 48238
Bennett, H. Stanley....15101 Southfield, Allen Park 48101
Bennett, Sanford A.............15301 W. Nine Mile Rd., Oak Park 48237
Bennish, Arvin..........17411 Greenfield, Detroit 48235
Bennish, E. Leo....14438 W. Six Mile Rd., Detroit 48240
Benson, Clifford D...1553 Woodward Ave., Detroit 48226
Benson, Davis A.........17563 Greenfield, Detroit 48235
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Benson, Virginia M. (L)....34636 Grove, Livonia 48154
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Bielawski, John G............825 David Whitney Bldg., Detroit 48226
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Binns, Philip M..........573 Fisher Bldg., Detroit 48202
Birch, John R.....633 Dav. Whitney Bldg., Detroit 48226
Birk, Robert E.....19787 Mack, Grosse Pte. Woods 48236
Birkam, Fred F.......7301 Schaefer Rd., Dearborn 48126
Birkhill, F. Ross...31 Shady Hollow Dr., Dearborn 48124
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Blain, Donald G...841 Balfour Rd., Grosse Pte. Park 48236
Blain, James H., Jr.......935 Grand Marais, Detroit 48230
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Blanks, Douglas H.....3955 Fort St., Lincoln Park 48146
Blass, Norman H............1800 Tuxedo, Detroit 48206
Blatt, Ronald W.....300 Cadillac Sq. Bldg., Detroit 48226
Bleier, Alfred......13015 E. Warren Ave., Detroit 48215
Blinkhorn, David H........25709 Salem, Roseville 48066
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Blondy, Marshall J...19009 W. 7 Mile Rd., Detroit 48219
Bloom, Albert............6484 Chene St., Detroit 48211
Bloom, Arthur R. (L)....19140 Gloucester, Detroit 48203
Bloom, Victor...........951 E. Lafayette, Detroit 48207
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Borin, Maurice C.......18115 Fairfield St., Detroit 48221
Bornstein, Melvin.............17600 Northland Pk. Ct., Southfield 48075
Bornstein, Sidney...........2033 Puritan, Detroit 48203
Borrego, Jose M..........1342 Whittier, Grosse Pte. 48236
Bott, Edmund T............1629 Ford, Wyandotte 48192
Botvinick, Isadore....13701 W. 7 Mile Rd., Detroit 48235
Boutrous, Thos. A.....15801 W. McNichols, Detroit 48235
Bower, Donald W......8863 Woodside, Grosse Ile 48138
Bowers, Leo J....11200 E. McNichols Rd., Detroit 48234
Bowersox, LeRoy W...................765 Balfour Rd., Grosse Pte. Park 48236
Bowlby, James R...15420 Farmington Rd., Livonia 48154
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Bradfield, R. John........955 Fisher Bldg., Detroit 48202
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Braverman, Morris M..............20905 Greenfield Rd., Southfield 48075
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Brennan, Michael J................1168 Three Mile Dr., Grosse Pte. 48236
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Bringard, Elmer L.....20905 Greenfield, Southfield 48075
Brinkman, G. L............Harper Hosp., Detroit 48201
Briski, Jacob E...1058 Blairmoor, Grosse Pte. Woods 48236
Brisson, John E..........17032 Fort St., Riverview 48192
Brisson, Jos. C. (R)...................23112 Westbury, St. Clair Shores 48080
Bristol, Wm. R..............189 Claverly, Detroit 48236
Broadman, Sylvan A...25705 Middlebelt, Farmington 48024
Brock, Donald R.....36475 Five Mile Rd., Livonia 48154
Broderson, Harvey S. (R)...........10720 W. Jefferson, River Rouge 48218
Bromme, Wm. (L).......10 Peterboro St., Detroit 48201
Brooks, Chas. W., II..2033 E. Davison St., Detroit 48212
Brooks, Eugene M............609 Northland Med. Bldg., Southfield 48075
Brooks, Nathan................7401 3rd St., Detroit 48202
Brosius, Chas. O....16981 Farmington Rd., Livonia 48154
Brosius, Wm. L. (L)..............1823 Fair Oak Court, Rochester 48063
Brown, Andrew G.....20905 Greenfield, Southfield 48075
Brown, Audrey O. (L).............1795 Cedar Hill Dr., Birmingham 48010
Brown, Carlton F.....22335 Lagaronne, Southfield 48075
Brown, Chas. H..........2387 Fort St., Wyandotte 48192
Brown, Donald........Henry Ford Hosp., Detroit 48202
Brown, Eli M...13123 La Salle, Huntington Woods 48070
Brown, Frances (L)
Brown, Gordon T.......13000 Hayes Ave., Detroit 48205
Brown, James C...........5050 Joy Road, Detroit 48204
Brown, John R...1145 Dav. Whitney Bldg., Detroit 48226
Brown, Kenneth A........13300 Livernois, Detroit 48238
Brown, Oscar A...1633 Dav. Whitney Bldg., Detroit 48226
Brown, Richard O............1800 Tuxedo, Detroit 48206
Brown, Robt. A. (A)........1524 Vernon, Trenton 48183
Brown, Saml. M..........21821 Harding, Oak Park 48237
Brown, Saul....6890 White Pine Dr., Birmingham 48010
Brown, Stanley H. (L).........8544 W. McNichols Rd., Detroit 48221
Brown, Thos. A.....5430 W. Warren Ave., Detroit 48210
Brownell, H. H.....8222 Woodcrest Dr., Grosse Ile 48138
Brownell, Paul G...18916 Woodward Ave., Detroit 48203
Bruce, Thomas A........19540 Shrewsbury, Detroit 48221
Bruder, Robt. C.....4520 Firestone Ave., Dearborn 48126
Bruer, Edgar S..........12170 Fort St., Wyandotte 48192
Bruer, Edwin L.........12170 Fort St., Wyandotte 48192
Brush, Brock E......2799 W. Grand Blvd., Detroit 48202
Bruton, Martin F........341 Massachusetts, Detroit 48203
Bryan, Donald I..................13700 Woodward Ave., Highland Park 48203
Buck, Raymond E.......1575 E. Lafayette, Detroit 48207
Buell, John H. (R).....188 Provencal Rd., Detroit 48236
Buerki, Robin C.........Henry Ford Hosp., Detroit 48202
Buettgen, Jan W............15540 Harper, Detroit 48224
Buller, Harry L. (A)............16120 Greenview Ave., Detroit 48219
Burge, Robert H.........23843 Joy Rd., Dearborn 48127
Burke, Ralph M.....580 University Pl., Grosse Pte. 48236
Burnham, Thomas K.....Henry Ford Hosp., Detroit 48202
Burns, Robert E........Henry Ford Hosp., Detroit 48202
Burns, Robt. T.........11110 Morang Rd., Detroit 48224
Burnside, Howard B...................33 Oakland Park, Pleasant Ridge 48069
Burnstine, David.........18400 Schaefer, Detroit 48235
Burnstine, Julius Y. (L).....45 Owen Ave., Detroit 48202
Burnstine, Perry P.....2329 W. Grand Blvd., Detroit 48208
Burr, Geo. C. (L)....1177 Devonshire, Grosse Pte. 48236
Burroughs, Roswell G............1309 D. Whitney Bldg., Detroit 48226
Burrows, Howard A. (A)........10423 W. Warren Ave., Dearborn 48126
Burstein, Harry S....2950 W. Grand Blvd., Detroit 48202
Burstein, I. Marvin...2950 W. Grand Blvd., Detroit 48202
Burton, De Witt T. (L)....54 Arden Park, Detroit 48202
Burton, Irving F......................26912 York Rd., Huntington Woods 48070
Burton, John F..........400 E. Lafayette, Detroit 48226
Bush, Glendon J......18901 W. McNichols, Detroit 48219
Butler, James E......2177 W. Grand Blvd., Detroit 48208
Butler, John D.......2173 W. Grand Blvd., Detroit 48208
Butler, Lawrence H...14521 East 7 Mile Rd., Detroit 48205
Butler, Richard G.........2021 Monroe, Dearborn 48124
Butler, Volney N.......28 W. Adams Ave., Detroit 48226
Buttrum, Edward J......14755 Fenkell St., Detroit 48227
Cabral, Hector H...24860 River Heights, Southfield 48075
Cabrera, Enrique.....35337 W. Warren, Westland 48184
Cadger, Ralph E. (M)...........719 New Center Bldg., Detroit 48202
Cahalan, Jos. L..........15830 Fort St., Southgate 48192
Cain, Waldo L......8401 Woodward Ave., Detroit 48202

Caldwell, Geo. L. (L)............12017 Joseph Campau, Detroit 48212
Caldwell, John R.....2799 W. Grand Blvd., Detroit 48202
Callaghan, Regis L......22146 Ford Rd., Dearborn 48128
Callaway, Charles L......Lafayette Clinic, Detroit 48207
Calmidis, Yani V..........15453 Mendota, Detroit 48238
Calwell, John G.....714 New Center Bldg., Detroit 48202
Cameron, Arthur H. (L)..............2853 Biddle Ave., Wyandotte 48192
Cameron, Duncan A.......2021 Monroe, Dearborn 48124
Campbell, Fredk. W., Jr.........648 N. Woodward Ave., Birmingham 48011
Campbell, Harvey E.....3 Robindale Ct., Dearborn 48124
Campbell, Malcolm D. (L).........1520 N. Gulley Rd., Dearborn 48128
Campbell, Mary B. (L)................10454 Kingston, Huntington Woods 48070
Campbell, Robt. E...8445 E. Jefferson Ave., Detroit 48214
Campbell, Ruth B....1536 David Whitney, Detroit 48226
Campbell, Thelma M. 2355 Monroe Blvd., Dearborn 48124
Camps, Enrique (A)..1543 Sherwood Ct., Dearborn 48124
Caneino-Samson, E. B...18700 Meyers Rd., Detroit 48235
Candler, Clarence L. (L)..815 Brown St., St. Clair 48079
Cantor, Herbert C................26831 N. Woodward, Huntington Woods 48070
Cantor, Meyer O..................4850 Charing Cross, Bloomfield Hills 48013
Cantow, Lawrence A.............19291 Warrington Dr., Detroit 48221
Cantrell, Mary E........Henry Ford Hosp., Detroit 48202
Capellari, Elmer E..............Box 3059, Detroit 48231
Capetamakis, D. C............15071 E. Seven Mile Rd., Detroit 48205
Capobres, David B.....3001 E. 7 Mile Rd., Detroit 48234
Caputo, Jos. M......2021 Monroe Blvd., Dearborn 48124
Caputo, Nancy T.....17712 Mack Ave., Grosse Pte. 48236
Capuzzi, Eugene T...24644 Gleneyrie Dr., Southfield 48075
Caraway, James E. (R)..................R. 1, Box 503, Franklin, N.C. 28734
Carbone, Louis........14711 Gratiot Ave., Detroit 48205
Carbonell, Tomas........353 Devonshire, Deraborn 48124
Carlisle, John C.......15101 Southfield, Allen Park 48101
Carlson, Harold W...18070 Wildemere Ave.. Detroit 48221
Carman, Kenneth W...30928 Ford Rd., Garden City 48135
Carnes, Harry E. (A)...........401 Lafayette Twrs. E., Detroit 48207
Carp, Jos.................8717 Van Dyke, Detroit 48213
Carpenter, C. J. (L)........P. O. Box 390, Wayne 48184
Carpenter, Glenn B. (L)......2751 W. Seven Mile Rd., Detroit 48221
Carpenter, Wm. S.............18255 W. McNichols Rd., Detroit 48219
Carr, James G. (L)..........14111 Korte, Detroit 48215
Carrick, Lee........18050 Mack Ave., Grosse Pte. 48236
Carroll, Elmer H. (L)...9920 Stoepel Ave., Detroit 48204
Carroll, Jerome G.....29588 Five Mile Rd.. Livonia 48154
Carroll, Lona B. (L)..........938 David Whitney Bldg., Detroit 48226
Carson, Herman J.......7745 Puritan Ave., Detroit 48238
Carstens, Henry R. (L)..........6896 N. Clunbury Rd., Birmingham 48010
Carter, James A. U......16637 Wildemere, Detroit 48221
Carter, John M. (L)............2860 N. E. 55th Court, Ft. Lauderdale, Fl. 33308
Carter, Leland F...........750 Middlesex, Detroit 48230
Case, Hilda B............261 Mack Blvd., Detroit 48201
Cash, Morton B........St. Mary's Hospital, Livonia 48151
Cash, Ralph....15705 W. Ten Mile Rd., Southfield 48075
Cassel, Harry E.........6742 Park Ave., Allen Park 48101
Castle, Maurice E........20211 Greenfield, Detroit 48235
Catalano, Joseph V.....20905 Greenfield, Southfield 48075
Caughey, Andrew F., Jr...15256 Levan Rd., Livonia 48154
Caughey, Edgar H......11301 Whittier St., Detroit 48224
Caumartin, Fred E.......17184 Wildemere, Detroit 48221
Cellar, Frank A., Jr...............26789 Woodward Ave., Royal Oak 48072
Ceravolo. Albert J........468 Cadieux Rd., Detroit 48230
Cetnar, Eugene J.............4322 Bishop, Detroit 48224
Chalat, Ned I.......1553 Woodward Ave., Detroit 48226
Chall, Henry G.....2941 W. McNichols Rd., Detroit 48221
Chapin, Sidney E.......125 N. Military, Dearborn 48124
Chapman, Aaron L. (L)............406 W. Frisco Rd., Pensacola, Fl. 32507
Chapman, Paul T........1151 Taylor Ave., Detroit 48202
Chapman, Roland H...3790 Woodward Ave., Detroit 48201
Chapnick, Henry A..........19335 Prairie, Detroit 48221
Chapper, Barbara M.........861 Monroe, Dearborn 48124
Charnas, Sidney..1129 Dav. Whitney Bldg., Detroit 48226
Charnley, Arnold D.....1678 Merriman Rd., Wayne 48184
Chase, Clyde H. (R).............2922 Dawes St. S.E., Grand Rapids 49508
Chason, Jacob L...........1401 Rivard St., Detroit 48207
Chavis, William M........13800 Livernois, Detroit 48238
Cheek, Frank E........76 W. Adams Ave., Detroit 48226
Chen, Allen S. Y....11933 Belleville Rd., Belleville 48111
Chen, Calvin H............State Hosp., Northville 48167
Chen, Shek C...........1326 St. Antoine, Detroit 48226
Cherenzia, B. J...7437 Wellbourne Ct., Birmingham 48010
Chesluk, Herman M.............17191 J. Couzens Hwy., Detroit 48235
Chester, Alice....25085 Coolidge Hwy., Oak Park 48237
Chester, Wm. P........28 W. Adams Ave., Detroit 48226
Childs, Geo. M......2970 W. Grand Blvd., Detroit 48202
Chipman, Willard A. (L)......14300 W. McNichols Rd., Detroit 48235
Chipoco, Adolfo M.....25210 Grand River, Detroit 48240
Chodorkoff, Bernard....19435 Shrewsbury, Detroit 48221
Chown, Marion C..........2025 Ford, Wyandotte 48192
Christensen, R. C...................20861 Mack Ave., Grosse Pte. Woods 48236
Christopher, James G................20295 Douglas Ct., Birmingham 48010
Chrouch, Laurence A. (L)......Pleasant Hill, Tn. 38578
Church, Aloysius........19570 Bretton Dr., Detroit 48223
Churchill, John A.........Lafayette Clinic, Detroit 48207
Cioffari, Mario S.............15924 W. Seven Mile Rd., Detroit 48235
Clapper, Muir...........1401 Rivard St., Detroit 48207
Clark, Arthur M.........401 River Lane, Dearborn 48124
Clark, Clarence M. (L)............2605 Holbrook Ave., Detroit 48212
Clark, Max D.....Wm. Beaumont Hosp., Royal Oak 48067
Clark, Wm. P...........1808 Baldwin, Ann Arbor 48104
Clarke, Chas. N..........21950 Greenfield, Detroit 48237
Clarke, Norman E. (L)...21950 Greenfield, Detroit 48237
Clarke, Norman E., Jr.....21950 Greenfield, Detroit 48237
Clarke, Robt. B........76 W. Adams Ave., Detroit 48226
Clemens, Raymond R.........23843 Joy, Dearborn 48127
Clermont, Volna............5050 Joy Rd., Detroit 48204
Clifford, John E..............18348 Mack, Detroit 48236
Climie, Andrew R. W.....Harper Hospital, Detroit 48201
Cline, Richard S......15101 Plymouth Rd., Detroit 48227
Clune, John P. (M)...........226 Eastland Prof. Bldg., Harper Woods 48236
Coates, E. Osborne, Jr...Henry Ford Hosp., Detroit 48202
Cobane, John H. (L)...10 Peterboro Ave., Detroit 48201
Cochrane, Edgar G...503 Med. Arts Bldg., Detroit 48203
Cocorelis, S. G. (A)..Jack Garris, Municipal Court Bldg., Ann Arbor
Cohen, David M.....1400 Chrysler Expwy., Detroit 48207
Cohen, Herbert H....12700 W. 7 Mile Rd., Detroit 48235
Cohen, Melvin F......20905 Greenfield, Southfield 48075
Cohn, Danl. E.............409 Fox Bldg., Detroit 48201
Cohn, S. Leonard........18055 Greenfield, Detroit 48235
Cohoe, Don A. (L)..18916 Woodward Ave., Detroit 48203
Cole, James E. (L).....344 Glendale Ave., Detroit 48203
Cole, Wyman C. C. (L)............1116 Leisure Lane, Walnut Creek, Ca. 94597
Cole, Wyman C. C., Jr............3011 W. Grand Blvd., Detroit 48202
Coleman, Margarete W. (L)...........4214 Woodward, Royal Oak 48072
Coleman, Peter F..........31410 Joy Rd., Livonia 48150
Coleman, Wm. G...20526 Grand River Ave., Detroit 48219
Coles, Thomas B., Jr.......Grace Hospital, Detroit 48201
Collings, M. Raymond (A)........9201 W. Outer Drive, Detroit 48219
Collins, James E...13103 W. Chicago Blvd., Detroit 48228
Collins, James W.........13800 Livernois, Detroit 48238
Colvin, Leslie T.....3011 W. Grand Blvd., Detroit 48202
Colyer, Raymond G. (R)..284 Pilgrim, Birmingham 48009
Combs, Julius V.............2424 Puritan, Detroit 48238

Comly, Hunter H.........5475 Woodward, Detroit 48202
Comstock, Lawrence A.....3700 West Rd., Trenton 48183
Conklin, Emma J....Wayne Co. Gen. Hosp., Eloise 48132
Conley, Lowry C. M. (L)..99 Tuxedo Ave., Detroit 48203
Connelly, Richard C................1360 Three Mile Dr., Grosse Pte. 48236
Connolly, Paul J...16778 Westmoreland Rd., Detroit 48219
Connors, John J....25657 Southfield Rd., Southfield 48075
Cook, Carla A. (A)..1538 Chateaufort Pl., Detroit 48207
Cook, James A........2246 20th Street, Wyandotte 48192
Cook, James C............3825 Brush St., Detroit 48201
Cookinham, Frank......999 S. Highland, Dearborn 48124
Cooksey, Warren B. (L)..........3535 W. 13 Mile Rd., Royal Oak 48072
Cooper, James B.....18150 Mack Ave., Grosse Pte. 48236
Cooper, Ralph R...1515 Dav. Whitney Bldg., Detroit 48226
Cooper, Richard F. 18100 Shadbrook Dr., Northville 48167
Cooper, Thomas M...8445 E. Jefferson Ave., Detroit 48214
Corbeille, Catherine (L)..........3011 W. Grand Blvd., Detroit 48202
Corbett, David P.........Harper Hospital, Detroit 48201
Cortez, Joseph A.....19350 W. McNichols, Detroit 48219
Costello, Russell T...3001 W. Grand Blvd., Detroit 48202
Costello, Stephen D.....9435 Island Dr., Grosse Ile 48138
Cotant, John F.......14044 W. McNichols, Detroit 48235
Cotton, Schuyler O. (R)......2332 Carson, Detroit 48209
Courville, Chas. J.............703 Northland Med. Bld., Southfield 48075
Cowan, Wilfrid (L)..764 Harcourt, Grosse Pte. Park 48230
Cowen, Leon B. (L).....1001 Kales Bldg., Detroit 48226
Cowen, Robt. L. (L)........91 E. Kirby, Detroit 48202
Cox, Frank, Jr..........Henry Ford Hosp., Detroit 48202
Coyle, James E......17770 Mack Ave., Grosse Pte. 48224
Craig, Roy D........3790 Woodward Ave., Detroit 48201
Craig, Roy E...74 Fontana Lane, Grosse Pte. Shores 48236
Crawley, Eugene H....................885 Bloomcrest, Bloomfield Hills 48013
Crews, Thos. H. (L)..3011 W. Grand Blvd., Detroit 48202
Crockett, E. E. J.........7341 W. Warren, Detroit 48210
Croll, Leo J..........12703 W. 7 Mile Rd., Detroit 48235
Croll, Maurice...12703 W. Seven Mile Rd., Detroit 48235
Crook, Chas. L.....60 Colorado St., Highland Park 48203
Cross, Harold E...68 N. Deepland Rd., Grosse Pte. 48236
Crossen, Robert J.....933 David Wh. Bldg., Detroit 48226
Croushore, James E. (L)......561 N.E. Golden Harbour, Boca Raton, Fl. 33432
Cruz, Victor M........20905 Greenfield, Southfield 48075
Cserhalmi, Maria V......1302 Beaconsfield, Detroit 48230
Cubberley, Robt. B.......1800 Tuxedo St., Detroit 48206
Cueto, Jose M.........23200 Woodward, Ferndale 48220
Cullis, Frank..................261 Brady, Detroit 48207
Curhan, Robert P.......18709 Meyers Rd., Detroit 48235
Curtis, Frank E. (L)....273 Kenwood Ct., Detroit 48236
Curtiss, Wm. P...22631 Mack Ave., St. Clair Shores 48080
Cusick, Paul L.....15901 W. 9 Mile Rd., Southfield 48075
Daignault, F. M.......20905 Greenfield, Southfield 48075
Daitch, Harold J...22341 W. Eight Mile Rd., Detroit 48219
Daitch, Martin H. 13011 W. McNichols Rd., Detroit 48235
Dale, Esther H...........1401 Rivard St., Detroit 48207
Dale, Mark............3702 E. 8 Mile Rd., Detroit 48234
Dal Santo, G.............1401 Rivard St., Detroit 48207
Daly, Eugene T............24781 Fenkell, Detroit 48223
Danforth, James C., Jr...............20175 Mack Ave., Grosse Pte. Woods 48236
Danforth, Robt. D..................20175 Mack Ave., Grosse Pte. Woods 48236
Danielski, John J..........35478 Parkdale, Livonia 48150
Danto, Bruce L..........466 Fisher Bldg., Detroit 48202
Danz, George W...........1539 Ford, Wyandotte 48192
Daoust, Patrick H.......15520 Garfield, Allen Park 48101
Darling, Chas. E.........673 Fisher Bldg., Detroit 48202
Davidson, Harry O...2799 W. Grand Blvd., Detroit 48202
Davies, Thos. S. (L)...............15115 E. Jefferson, Grosse Pte. 48230
Davies, Windsor S.......28 W. Adams Ave., Detroit 48226
Davis, Herbert A......9901 Melbourne, Allen Park 48101
Davis, Jerome D. (M)............19075 Middlebelt Rd., Livonia 48152
Dawson, W. A. (R)..........188 Lake Silver Dr. N.W., Winter Haven, Fl. 33880
Day, A. Jackson.........245 Cloverly Rd., Detroit 48236
Day, Francis T..............18540 Mack, Detroit 48236
Day, Jay C.............1016 Prof. Plaza, Detroit 48201
Day, Ruth S.........3790 Woodward Ave., Detroit 48201
Dayioglu, Vehbi...27560 Cherry Hill, Garden City 48135
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Dean, Carleton R. (M)...........Off. of Vocnl. Rehab., 42 Broadway, Rm. 120, New York, N.Y. 10004
Dean, George A.........19309 Greenfield, Detroit 48235
Deboyrie, Emile A. (A)
De Busk, Roger W........4160 John R St., Detroit 48201
Deering, Robt. J.....1359 Champaign, Lincoln Park 48146
De Groat, Albert F. (L)..1151 Taylor Ave., Detroit 48202
Deitch, Daniel..........4059 W. Davison, Detroit 48238
De Jongh, Edwin....Gen. Motors Building, Detroit 48202
Delaini, Stella M.....3011 W. Grand Blvd., Detroit 48202
De Lawrence, Betty J.............21576 Michigan Ave., Dearborn 48124
De Lawrence, Thomas............21576 Michigan Ave., Dearborn 48124
Del Giorno, Thos. E. (A)................Mecosta 49332
Delguidice, P. A...........Grace Hospital, Detroit 48201
Del Valle, Francisco....3729 Fort St., Lincoln Park 48146
Del Valle, Mario..........19936 Packard, Detroit 48234
Dennis, Melvin S. (A)..22146 Ford Rd., Dearborn 48127
Denson, Andrew L. (A)..2224 Hazlewood, Detroit 48206
Deresz, Alphonse R.....4204 E. Outer Dr., Detroit 48234
Derleth, Paul E.....563 W. Oakridge Ave., Ferndale 48220
Derr, John W.....1145 Dav. Whitney Bldg., Detroit 48226
Derrick, C. F.......3677 Fort Street, Lincoln Park 48146
Deryke, Gilbert R.......35006 Wood Drive, Livonia 48154
De Smyter, Geo. C.......15527 E. Warren, Detroit 48224
De Spelder, Ray E...2970 W. Grand Blvd., Detroit 48202
Deuby, Owen J...15121 W. Seven Mile Rd., Detroit 48235
Devine, Herbert W.......22101 Moross Rd., Detroit 48236
Diakow, Lilian M.....1539 N. Line Rd., Wyandotte 48192
Dibble, Harry F. (L)....9500 Lasalle Blvd., Detroit 48206
Dickenman, Robert C...........Detroit Memorial Hosp., Detroit 48226
Dicksheet, Sharad K.....1846 West Road, Trenton 48183
Dickson, Basil R......337 W. Grand Blvd., Detroit 48216
Dickson, Elias L., Jr.......17320 Livernois, Detroit 48221
Dickson, Laurie C., Jr...400 Lincoln Rd., Grosse Pte. 48236
Dickson, Leon A........5535 W. Chicago, Detroit 48204
Dickson, Mary D.
Diebel, Nelson W........660 Cadieux Rd., Detroit 48230
Diekman, Fred C. 31815 Southfield Rd., Birmingham 48009
Dietze, Margaret R.........861 Monroe, Dearborn 48124
Dietzel, Hugo O. (R)................844 Hemlock Dr., San Carlos, Ca. 94070
Di Lella, Leonard L.....Henry Ford Hosp., Detroit 48202
Dill, Hugh L. (L)..16114 E. Warren Ave., Detroit 48224
Dill, J. Lewis............18615 Birchcrest, Detroit 48221
Dillon, Thomas K. (A).....22250 Puritan, Detroit 48223
Di Loreto, Panfilo C.....285 Vincennes Pl., Detroit 48236
Di Maso, Gennaro J......20963 Kelly, East Detroit 48021
Dimond, Geo. E.........18401 Bretton Dr., Detroit 48223
Dipiero, Raniero............1800 Tuxedo, Detroit 48206
Dittmer, Edwin F....18342 Mack Avenue, Detroit 48236
Dixon, Fredk. W.........245 S. Martha, Dearborn 48124
Dixon, Ray S. (L)........5001 Van Dyke, Detroit 48213
Dodds, John C. (L)..18520 W. 7 Mile Rd., Detroit 48219
Dodenhoff, Chas. F.......18031 Kelly Rd., Detroit 48224
Dodrill, Forest D...Woodberry Dr., Bloomfield Hills 48013
Doering, Wendell R...17555 James Couzens, Detroit 48235
Doig, Victor F...............19676 Dale, Detroit 48219
Dolan, Edward A.............1960 Hammond Lake Dr., Pontiac 48053
Dolega, Stanley F...15640 E. Warren Ave., Detroit 48224
Dolgoff, Sidney....15600 Michigan Ave., Dearborn 48126
Dolin, Simon..........28500 Bell Rd., Southfield 48075
Domjancic, John T..................Outer Drive Hosp., Lincoln Park 48146
Domzalski, Henry M...15252 Gratiot Ave., Detroit 48205
Donath, Rolf W.....719 New Center Bldg., Detroit 48202
Donovan, Eugene T. 13349 Michigan Ave., Dearborn 48126
Donovan, Richard S...17555 James Couzens, Detroit 48235
Do Pico, Alfredo J. 6221 Merriman Rd., Garden City 48135
Doran, John H........15101 Plymouth Rd., Detroit 48227
Dorman, Jack.............18831 Fairfield, Detroit 48221
Dorostkar, M. G....................24752 Currier Ave., Dearborn Hghts. 48127

Dorsey, Edward C.......8344 E. Jefferson, Detroit 48214
Dorsey, John M.....65 Moss Avenue, Highland Park 48203
Doty, Chester A. (L)............135 E. Maryland Ave., Phoenix, Az. 85012
Doub, Howard P. (L)............2799 W. Grand Blvd., Detroit 48202
Dougherty, Edw. A., Jr.........18241 W. McNichols Rd., Detroit 48219
Douglas, Clair L. (L)..............1201 Richmond St., London, Ont., Canada
Douglass, Robt. C..............23023 Orchard Lake Rd., Farmington 48024
Dovitz, Benj. W.....16820 Greenfield Ave., Detroit 48235
Downer, Ira G. (L)..8445 E. Jefferson Ave., Detroit 48214
Downes, Geo. O............15062 Houston, Detroit 48205
Drake, Ellet H.........Henry Ford Hosp., Detroit 48202
Drapiza, Ruth L.....22231 W. Outer Dr., Dearborn 48124
Draves, Edward F..........19647 Joy Rd., Detroit 48228
Drazek, Jos. A..........14001 Greenfield, Detroit 48227
Dreyer, Joel......15800 W. McNichols Rd., Detroit 48235
Drouin, Michel (A).......V.A. Hospital, Dearborn 48121
Drozdowska, Z. J. F............1413 Lafayette Twrs. W., Detroit 48207
Drumm, John K.......1420 St. Antoine St., Detroit 48226
D'Sena, Dorothy........33000 Palmer Rd., Wayne 48184
Dubin, Jos. J..............1420 Strathcona, Detroit 48203
Dubpernell, Martin S. (L)..4019 Gilbert St., Detroit 48210
Dubpernell, Robt. O....18595 Grand River, Detroit 48223
Dudek, John J.........19244 Grand River, Detroit 48223
Dumke, Paul R......2799 W. Grand Blvd., Detroit 48202
Duncan, James R...........5050 Joy Rd., Detroit 48204
Dundas, Edward M., Jr...4520 Firestone, Dearborn 48126
Dunlap, Henry A...7815 Jefferson Ave. E., Detroit 48214
Dunn, Cornelius E. (L)..17230 Mack Ave., Detroit 48236
Dupler, Gerald E...24234 Michigan Ave., Dearborn 48124
Durham, Everett W..............23100 Cherry Hill Rd., Dearborn 48124
Durham, Robt..........Henry Ford Hosp., Detroit 48202
Dutcher, Dwight J..........711 S. Oxford, Detroit 48236
Duwe, Frank A.......25321 Five Mile Rd., Detroit 48239
Dwaihy, Paul J. (A).....14530 E. Warren, Detroit 48215
Dwyer, Francis W....14440 W. McNichols, Detroit 48235
Dyer, H. Lorne.........115 E. Dunlap, Northville 48167
Dykema, Rosemary M.....18424 Mack Ave., Detroit 48236
Dziuba, John F.....18901 W. Warren Ave., Detroit 48228
Dzul, Paul...........17800 E. 8 Mile Rd., Detroit 48236
Eades, Chas. C..........19635 Mack Ave., Detroit 48236
Easterly, Robt. L.....1404 Ford Avenue, Wyandotte 48192
Eaton, Crosby D. (L)............3011 W. Grand Blvd., Detroit 48202
Echt, Raymond J.........V.A. Hospital, Dearborn 48121
Eckhous, Arthur W.......1015 Kales Bldg., Detroit 48226
Economy, Donald E.....18 W. Lane Ct., Dearborn 48124
Eder, Saml. J. (L)......19541 Cranbrook, Detroit 48221
Edgar, Irving I...1036 Dav. Whitney Bldg., Detroit 48226
Edmonds, Gerald W.................216 Afton Brae Dr., Anniston, Al. 36201
Edmonds, Wm. N. (L)...........18525 Merriman Rd., Livonia 48152
Edmondson, Robt. B.....18501 Mack Ave., Detroit 48236
Edwards, C. Rupert L...........Detroit Receiving Hosp., Detroit 48226
Edwards, James G...17751 E. Warren Ave., Detroit 48224
Egan, Charles F.................Wyandotte Gen. Hosp., Wyandotte 48192
Eisenbrey, A. B.........1026 Fisher Bldg., Detroit 48202
Eisenstein, B.............459 Fisher Bldg., Detroit 48202
Eldredge, Edward F...18540 Mack Ave., Grosse Pte. 48236
Elie, Jean C......938 Dav. Whitney Bldg., Detroit 48226
Elliott, Jos. P., Jr........Henry Ford Hosp., Detroit 48202
Elliott, Robt. N..........760 Fisher Bldg., Detroit 48202
Ellis, Frank R..........800 S. Lafayette, Dearborn 48124
Elman, Meyer J..........108 W. Hancock, Detroit 48201
Elson, Abraham L........Lafayette Clinic, Detroit 48207
Elton, Richard F. (A)......20058 Chapel, Detroit 48219
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Enfroy, Henri L...7421 W. Seven Mile Rd., Detroit 48221
Engel, Earl H...2336 Van Alstyne Blvd., Wyandotte 48192
Engstrom, Fredk. W........2021 Monroe, Dearborn 48124
Engstrom, Ruby M.....1777 Culver Ave., Dearborn 48124
Eno, Laurel S.......212 Eastland Pr. Bldg., Detroit 48236
Ensign, Dwight C......Henry Ford Hosp., Detroit 48202
Eppler, William R. (A).............43 Harris Dr. East, Ft. Rucker, Al. 36360
Epstein, Burton S........18215 Greenfield, Detroit 48235
Erickson, Eldon W................25750 W. Outer Dr., Lincoln Park 48146
Erickson, Miles A......1932 Ford Ave., Wyandotte 48192
Ericsson, Arthur D........Harper Hospital, Detroit 48201
Ericsson, Judith A...719 New Center Bldg., Detroit 48202
Erman, Jos. M........19530 Stratford Rd., Detroit 48221
Ermete, Sait D.....32633 Cherry Hill, Garden City 48135
Ernst, Reginald H...........5050 Joy Rd., Detroit 48204
Eschbach, Jos. W.....935 S. Military St., Dearborn 48124
Eurs, Frank J.......1340 Maccabees Bldg., Detroit 48202
Evans, Gomer P., Jr...1553 Woodward Ave., Detroit 48226
Evans, Jos. M..............16431 Harper, Detroit 48224
Evans, Tommy N.......18630 Fairway Dr., Detroit 48221
Ewing, Chas H..........17120 E. Warren, Detroit 48224
Eyler, Wm. R.......2799 W. Grand Blvd., Detroit 48202
Eyres, Alfred E.......17800 E. Eight Mile, Detroit 48236
Faehnie, Harold L....17401 Greenfield Rd., Detroit 48235
Faello, Sebastian J...16840 E. Warren Ave., Detroit 48224
Fagan, James P..........987 E. Jefferson, Detroit 48207
Fagin, Irving D......18254 Livernois Ave., Detroit 48221
Fahim, Ramfis B.......14634 E. 7 Mile Rd., Detroit 48205
Falick, Mordecai L........18652 Birchcrest, Detroit 48221
Falk, Ira E............17411 Cherrylawn, Detroit 48221
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Fargotstein, Ralph......St. Johns Hospital, Detroit 48236
Farina, Angel M...........23550 Joy Rd., Detroit 48239
Farjardo, A. C..........Oakwood Hosp., Dearborn 48124
Farmer, Wm. L., Jr.......3335 W. Davison, Detroit 48239
Farnam, Larry M., Jr........6200 Cadieux, Detroit 48224
Faunce, Sherman P......1824 Seminole St., Detroit 48214
Fea, John F......Mt. Carmel Mercy Hosp., Detroit 48235
Fedeson, Maureen S...........Mt. Carmel Mercy Hosp., Detroit 48235
Fedeson, Theodore M..........Mt. Carmel Mercy Hosp., Detroit 48235
Feigelson, Howard H.......Sinai Hospital, Detroit 48235
Feld, David.....15101 W. McNichols Rd., Detroit 48235
Feldkamp, Lee E...........360 N. Main, Plymouth 48170
Feldman, Irwin..........37380 Glenwood, Wayne 48184
Feldman, Nathanial L...........16202 Cumberland 104, Southfield 48075
Feldman, Paul H.........16800 Greenfield, Detroit 48235
Feldstein, Martin Z............13345 W. McNichols Rd., Detroit 48235
Fellner, Wm. A...3 202 Gen. Motors Bldg., Detroit 48202
Fellows, William R..........3815 Pelham, Dearborn 48124
Fenech, Harold B.........3790 Woodward, Detroit 48201
Fenner, Wm. G.......12454 E. Outer Dr., Detroit 48224
Fennessey, John F.........512 Rivard, Grosse Pte. 48236
Fenton, James L. (M)..........1615 Birmingham Blvd., Birmingham 48009
Fenton, Meryl M...15901 W. 9 Mile Rd., Southfield 48075
Fenton, Russell F...15125 Grand River Ave., Detroit 48227
Fenton, Stanley C. (L)...15618 E. Warren, Detroit 48224
Fentress, Vance..1501 Dav. Whitney Bldg., Detroit 48226
Feringa, Philip J........20901 Moross Rd., Detroit 48236
Fernandez-Pena, C. E. (A)....Grace Hosp., Detroit 48201
Fernando, Oscar (A)......Grace Hospital, Detroit 48201
Ferrara, Richard J...................20045 Mack Ave., Grosse Pte. Woods 48236
Ferrara, Virginia M......18422 Woodward, Detroit 48203
Ferrari, Fulvio M...Northville St. Hosp., Northville 48167
Ferris, George N.........20001 Greenfield, Detroit 48235
Ferszt, Marion S.........15369 Grandville, Detroit 48223
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Figiel, Steven J...........4160 John R St., Detroit 48201
Filkin, Lawrence E.......621 Fairbrook, Northville 48167
Fill, Leon..........2310 Cass, Exec. Suite, Detroit 48201
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Finch, F. Sinclair........894 N. Renaud, Detroit 48236

Finck, Jerome H.........25841 Plymouth, Detroit 48239
Fine, Edward..........1112 Kales Bldg., Detroit 48226
Fine, Gerald...........Henry Ford Hosp., Detroit 48202
Fink, Saml...............10161 Burton, Oak Park 48237
Finkelstein, I. S..........17508 Dorset, Southfield 48075
Finkelstein, M. B.........18254 Livernois, Detroit 48221
Firestone, N. S. (M)..............24671 Martha Wash., Southfield 48075
Firnschild, Paul G......8 Shady Hollow, Dearborn 48124
Fischer, Arthur J.....36016 Five Mile Rd., Livonia 48154
Fischer, Fredk. J.........654 Fisher Bldg., Detroit 48202
Fishbein, Herbert L...987 E. Jefferson Ave., Detroit 48207
Fisher, Geo. S....1709 Dav. Whitney Bldg., Detroit 48226
Fisher, James M.....176 Merriweather, Grosse Pte. 48236
Fitzgerald, C. H...Wayne Co. Gen. Hospital, Eloise 48132
Fitzgerald, James M...15801 W. McNichols, Detroit 48235
Fitzpatrick, F. W..........17187 Schaefer, Detroit 48235
Flaherty, Henry J.............19600 W. McNichols Rd., Detroit 48219
Flaherty, Norman W..............24315 Fairmont Dr., Dearborn 48124
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Fly, Marie N.........Oakwood Hospital, Dearborn 48124
Fogt, Robt. G.........16829 Harper Ave., Detroit 48224
Foley, Hugh S. (L).....1013 Haugh St., Dearborn 48124
Foote, John A....1336 Southfield Rd., Lincoln Park 48146
Ford, Geo. A. (L).....28 W. Adams Ave., Detroit 48226
Fordell, Frank S.....22159 W. Outer Dr., Dearborn 48124
Forgrave, Edward G....18520 Grand River, Detroit 48219
Forrer, Gordon R....20141 James Couzens, Detroit 48235
Fosnaugh, Robert P...23185 Timberline, Southfield 48075
Foster, E. Bruce....20905 Greenfield Rd., Southfield 48075
Foster, Owen C. (L)............1553 Woodward Ave., Detroit 48226
Foster, Wallace M...............13700 Woodward Ave., Highland Park 48203
Fountain, Charles W.....23851 Ford Rd., Dearborn 48128
Fowler, Melvin E......247 E. Warren St., Detroit 48201
Fox, Thomas A., Jr.....Henry Ford Hosp., Detroit 48202
Fraiberg, Paul L.......1454 Strathcona Dr., Detroit 48203
Frame, Boy.........18694 Warrington Dr., Detroit 48221
France, Chas. J...17800 E. Eight Mile Rd., Detroit 48236
Franjac, Marion J.....25447 Plymouth Rd., Detroit 48239
Frankel, Maurice A...............17000 W. Eight Mile, Southfield 48075
Franklin, John E.............4075 Ink Rd., Inkster 48141
Franzen, Nils A.......15360 Oakfield Ave., Detroit 48227
Frederickson, Geo. C.........7430 Second, Detroit 48202
Free, Harry W.......14300 W. McNichols, Detroit 48235
Freedman, Arthur M.....7701 Wyoming, Dearborn 48126
Freedman, John (R)....4853 Second Blvd., Detroit 48201
Freeman, Donald K.......881 Chalmers St., Detroit 48215
Freeman, Mable (L)..........1316 Dav. Broderick Twr., Detroit 48226
Freeman, Michael W....1810 Wellesley Dr., Detroit 48203
Freeman, Wilmer.....940 East 7 Mile Rd., Detroit 48203
Freid, Samuel.............17537 Parkside, Detroit 48221
Freier, Andrew A....18597 W. Ten Mile, Southfield 48075
Freier, Morton L......13051 Puritan Ave., Detroit 48227
Freilich, Olga......Crittenden Gen. Hosp., Detroit 48206
Freitas, Eugene L.......St. Johns Hospital, Detroit 48236
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Friedlaender, Sidney..........10300 W. Seven Mile Rd., Detroit 48221
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Friedman, David.........1333 Strathcona, Detroit 48203
Friedman, Isidor H. (L)..3773 Second Ave., Detroit 48201
Friedman, Seymour......5132 Allen Rd., Allen Park 48101
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Frost, Richard G............1800 Tuxedo, Detroit 48206
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Galantowicz, Thos. H.....23601 Ford Rd., Dearborn 48128
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Gall, Henry........10531 Farmington Rd., Livonia 48150
Gallagher, James P.......6535 Allen Rd., Allen Park 48101
Gallant, Vincent J...........16766 Ashton, Detroit 48219
Ganos, Thos...........6742 Park Ave., Allen Park 48101
Gans, Robert I....7310 W. Seven Mile Rd., Detroit 48221
Ganschow, John H.....1840 Holbrook Ave., Detroit 48212
Garcia, Remigio........Henry Ford Hosp., Detroit 48202
Gardner, Lawrence W...6071 W. Outer Dr., Detroit 48235
Gardner, Max L.....19557 Mack Ave., Grosse Pte. 48236
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Gass, H. Harvey.........529 Fisher Bldg., Detroit 48202
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Gilbert, Harold R........13146 Phelps, Wyandotte 48192
Giles, Conrad L...............407 Northland Med. Bldg., Southfield 48075
Gillespie, Stephen M...23100 Cherry Hill, Dearborn 48124
Gilpin, Watson A...1539 Lockridge, Bloomfield Hills 48013
Gilreath, James L...........1800 Tuxedo, Detroit 48206
Gilroy, John.............Harper Hospital, Detroit 48201
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Ginsberg, Harold I...15344 McNichols Rd., Detroit 48235
Girnius, Birute.............15439 Harper, Detroit 48224
Gitlin, Chas. (L)......2424 Oakman Blvd., Detroit 48238
Gittins, Perry C. (L)..............20905 Greenfield Rd., Southfield 48075
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Glement, Raymond D. (L).........16126 Woodring Ct., Livonia 48154
Glikman, Victor.....20131 James Couzens, Detroit 48235
Glowacki, Ben F. (L)..............8 Mile & Greenfield, Southfield 48075
Glowacki, Edward T.............20162 Wedgewood Dr., Grosse Pte. Woods 48236
Glowacki, Raymond M......961 Monroe, Dearborn 48124
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Goerke, Elmer A......36663 Goddard Rd., Romulus 48174
Goetz, Angus G. (L)..1553 Woodward Ave., Detroit 48226
Goins, Wm. F.........9340 Lasalle Blvd., Detroit 48206
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Goldberg, Harry H. (L)..........2211 Woodward Ave., Detroit 48201
Goldberg, Nathan H. (L).........2211 Woodward Ave., Detroit 48201
Golden, Alfred..26764 York Rd., Huntington Woods 48070
Goldfaden, Alfred.......9122 W. Fort St., Detroit 48209
Goldman, Aubrey....17191 James Couzens, Detroit 48235
Goldman, Perry........18050 Fairway Dr., Detroit 48221
Goldman, Robert T...Wayne County Hospital, Eloise 48132
Goldrath, Milton H................17000 W. 8 Mile Rd., Southfield 48075
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Goodman, Virgil P.....................762 Bedford Rd., Grosse Pte. Park 48236
Goodwin, Warren W. 20101 James Couzens, Detroit 48235
Goodwin, William P......1616 Boston W., Detroit 48206
Gordon, Marvin
Gordon, Seymour B. (A).....Grace Hosp., Detroit 48201
Gordon, Wm. E..........18058 Greenfield, Detroit 48235
Gorelick, Martin J...23901 Michigan Ave., Dearborn 48124
Goryl, Stephen V.........21501 Kelly, East Detroit 48021
Goss, Saml. B................10 Peterboro, Detroit 48201
Gostine, Edmond J.........9750 Chalmers, Detroit 48213
Gotham, James E..........3825 Brush St., Detroit 48201
Gotman, Abraham G..............987 E. Jefferson Ave., Detroit 48207
Gottlieb, Jacques S.......951 E. Lafayette, Detroit 48207
Gouda, Salah E. A.......28633 Hoover Rd., Warren 48093
Goux, Raymond S. (L)...........17566 Muirland Ave., Detroit 48221
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Grady, Jos. A.........946 Three Mile Dr., Detroit 48230
Graham, John G., Jr...491 Lincoln Rd., Grosse Pte. 48236
Graham, Theodore N.........2424 Puritan, Detroit 48238
Granger, Francis L.....14160 Gratiot Ave., Detroit 48205
Granger, George R...........705 David Whitney Bldg., Detroit 48226
Grant, Abraham H...22454 Chatsford Cir., Southfield 48075
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Green, Ellis R. (L).....5172 Seotten Ave., Detroit 48210
Green, Henry L.........17214 Jeanette, Southfield 48075
Green, Lewis..........13000 Grand River, Detroit 48227
Green, Milton M...17000 W. 8 Mile Rd., Southfield 48075
Green, Nelson W.................31815 Southfield Rd., Birmingham 48009
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Greenberg, Jack R............15821 W. Seven Mile Rd., Detroit 48235
Greenberg, Julius J.....5328 W. Outer Dr., Detroit 48235
Greenberg, Morris Z.......9105 Van Dyke, Detroit 48213
Greenberg, Stanley....20905 Greenfield, Southfield 48075
Greene, John B.....2179 W. Grand Blvd., Detroit 48208
Greene, Thomas J. (A)....2425 W. Boston, Detroit 48206
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Gregory, Louis J.........47 Webber Place, Detroit 48236
Grekin, John N...7421 W. Seven Mile Rd., Detroit 48221
Griffin, Robert J.........17401 Mack Ave., Detroit 48224
Griffiths, Sydney J.....15400 Plymouth Rd., Detroit 48227
Grimaldi, Gregory J. (A)...2983 Seminole, Detroit 48214
Grinstein, Alexander.....18466 Wildemere, Detroit 48221
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Griva-Lizlovs, Sylvia..29901 Ford Rd., Garden City 48135
Griz, John...........3815 Pelham Rd., Dearborn 48124
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Gudes, David S.........1080 Fisher Bldg., Detroit 48202
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Guevara, Omar......29901 Ford Rd., Garden City 48135
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Guindi, Sami F.........1080 Fisher Bldg., Detroit 48202
Gulick, Arthur E.............4160 John R, Detroit 48201
Gurdjian, Elisha S...1553 Woodward Ave., Detroit 48226
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Gutow, Benjamin R..........20867 Mack, Detroit 48236
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Haddad, Elias D.....14636 E. Seven Mile, Detroit 48205
Hadesman, Donald.......985 E. Jefferson, Detroit 48207
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Hagermoser, H. H...412 Eastland Ctr. Bldg., Detroit 48236
Hagge, Donald R...29594 W. Five Mile Rd., Livonia 48154
Haidostian, B. H.......18456 Grand River, Detroit 48223
Haines, Ellen R.............525 Seyburn, Detroit 48214
Haitinger, K. S........22175 Thorofare, Grosse Ile 48138
Haking, Leonard....14014 E. 7 Mile Rd., Detroit 48205
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Hall, Winthrop D...5237 Oakman Blvd., Dearborn 48126
Hallen, Leonard J........1335 Nicolet Pl., Detroit 48207
Hamburg, Robt. H............1515 Dav. Whitney Bldg., Detroit 48226
Hamburger, Albert C...13345 W. McNichols, Detroit 48235
Hamburger, Stuart W.............18400 Sehaefer Hwy., Detroit 48235
Hamil, Brenton M......Henry Ford Hosp., Detroit 48202
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Hanlon, John J.....316 City County Bldg., Detroit 48226
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Hanyi, Karl..........7645 Thornwood, Plymouth 48170
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Hardt, Barbara A......1301 Orleans, #303, Detroit 48207
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Harkaway, Roman W.....19125 Van Dyke, Detroit 48234
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Harley, Louis M...4100 W. McNichols Rd., Detroit 48221
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Harmon, Walter, Jr.......2510 E. Davison, Detroit 48212
Harnett, R. W. F.........529 Fisher Bldg., Detroit 48202
Harper, James H...Detroit Memorial Hosp., Detroit 48226
Harper, Jesse T...1110 Dav. Whitney Bldg., Detroit 48226
Harrington, Edw. B...............14853 Michigan Ave., Dearborn 48126
Harrington, F. L...14044 W. McNichols Rd., Detroit 48235

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Harris, Harold H.............8011 W. Vernor Highway, Detroit 48209
Harris, Ivor D....1245 David Whitney Bld., Detroit 48226
Harrity, William A.............302 Eastland Prof. Bldg., Detroit 48236
Hart, Charles E.....23845 Van Dyke, Center Line 48015
Hart, John C...............9341 Moffat, Detroit 48213
Hart, Zwi H.........800 N. Gulley Rd., Dearborn 48128
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Hassig, Walter W.......20914 Kelly, East Detroit 48021
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Heil, Edward R.........19190 Greenfield, Detroit 48235
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Henderson, Frederic C...18101 E. Warren, Detroit 48224
Henderson, Hugh W.....18101 E. Warren, Detroit 48224
Henderson, Leslie T. (L)..14814 E. Warren, Detroit 48215
Henderson, Wm. E. (L)..18101 E. Warren, Detroit 48224
Hendra, Alan K............15540 Harper, Detroit 48224
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Henkin, Raymond......17228 Shervilla, Southfield 48075
Henkin, Wm. A.........18215 Greenfield, Detroit 48235
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Herschelmann, Roy F....3343 Gratiot Ave., Detroit 48207
Hershey, Ernest A., Jr..........307 Dav. Whitney Bldg., Detroit 48226
Hertzler, Jack H.....3011 W. Grand Blvd., Detroit 48202
Herwick, John T.....2799 W. Grand Blvd., Detroit 48202
Hess, Joseph W..........Harper Hospital, Detroit 48201
Hess, Murray W............30650 Bruce, Franklin 48025
Hessburg, Philip C.....Henry Ford Hosp., Detroit 48202
Heyman, Louis F.............19009 W. Seven Mile Rd., Detroit 48219
Heyner, C. S.....15901 W. 9 Mile Rd., Southfield 48075
Heyner, Fredk. J...........3424 Oakman, Detroit 48204
Heyner, Stanley A.....3424 Oakman Blvd., Detroit 48204
Hickey, Jos. (L).....23100 Cherry Hill, Dearborn 48124
Hicks, Fredk. G......1000 Westwood, Birmingham 48009
High, Robert H.........Henry Ford Hosp., Detroit 48202
Higuera, J. Gilberto..13700 Woodward Ave., Detroit 48203
Hill, Edward J., Jr.............949 Dav. Whitney Bldg., Detroit 48226
Hill, George C..............5050 Joy Rd., Detroit 48204
Hill, Raymond D......14551 Southfield, Allen Park 48101
Hill, Welford T..........6303 Mack Ave., Detroit 48207
Hillenberg, Sidney J...19370 W. 7 Mile Rd., Detroit 48219
Hiller, Glenn I......13700 Woodward Ave., Detroit 48203
Hillyer, John W.........3700 West Road, Trenton 48183
Hilton, Wm. E. (L).........5013 Harding, Detroit 48213
Hinchman, D. F....10865 Farmington Rd., Livonia 48150
Hipps, Chauncey J...2605 West Grand Blvd., Detroit 48208
Hirsch, Leo J........15800 W. McNichols, Detroit 48235
Hirsch, Lore...........212 S. Melborn, Dearborn 48124
Hirschfeld, A. H.........3790 Woodward, Detroit 48201
Hoagland, F. L. (A)..716 E. Grand Blvd., Detroit 48207
Hobbs, Donald V.................27305 Southfield Rd., Lathrup Village 48075
Hochman, Morton M...16633 Plymouth Rd., Detroit 48227
Hodges, Jason......26401 Harper, St. Clair Shores 48081
Hodgkinson, Chas. P.............17546 Meadwood Ave., Lathrup Village 48075
Hoffer, Thos...........5825 Allen Rd., Allen Park 48101
Hoffman, Ben G........19545 Shrewsbury, Detroit 48221
Hoffman, Edward A...7615 W. Vernor Hwy., Detroit 48209
Hoffman, Edwin S. (R)..........8106 E. Jefferson Ave., Detroit 48214
Hoffman, Harry Y.............15085 E. Seven Mile Rd., Detroit 48205
Hoffman, Henry A.....10015 E. Outer Dr., Detroit 48224
Hoffman, Louis......19308 Wyoming Ave., Detroit 48221
Hoffman, Milton C.......18555 E. Warren, Detroit 48236
Hogikyan, Azat..16901 W. McNichols Rd., Detroit 48235
Holdredge, Jean M...3011 W. Grand Blvd., Detroit 48202
Hollander, Abraham J.............14327 Michigan Ave., Dearborn 48126
Hollinger, F. Wayne..8265 Gen. Mtrs. Bldg., Detroit 48202
Hollis, Henry B..............6809 Sirena, Detroit 48210
Holloway, Horace R.......12840 Linwood, Detroit 48238
Holloway, Janet L...........7430 Second, Detroit 48202
Hollowell, M. L......10720 W. 7 Mile Rd., Detroit 48221
Holmes, Geo. F......14729 Champaign, Allen Park 48101
Holt, Chas. J., Jr.......1210 S. Oxford, Grosse Pte. 48236
Holt, Henry T.............5050 Cass St., Detroit 48202
Holt, W. S., Jr.........Mt. Carmel Hosp., Detroit 48235
Homeister, Eugene A..........12925 Pennsylvania Ave., Wyandotte 48192
Honet, Joseph C...........Sinai Hospital, Detroit 48235
Honhart, Fred L. (L)............1405 Berkshire Road, Grosse Pte. 48230
Hopkins, Andrew J........4407 Roemer, Dearborn 48126
Hopkins, George C............3183 Mack, Detroit 48207
Hopkins, Scovell M...........910 Dav. Broderick Twr., Detroit 48226
Horkins, Earl J.........32300 Schoolcraft, Livonia 48154
Horn, Robt. C., Jr....2799 W. Grand Blvd., Detroit 48202
Hornbeck, Robert J...31500 Schoolcraft Rd., Livonia 48150
Horny, Hugo O........619 Barrington Rd., Detroit 48230
Horrell, Eugene D.......1480 Kales Bldg., Detroit 48226
Horton, Marley G., Jr......4407 Roemer, Dearborn 48126
Horton, Reece H...............606 Northland Med. Ctr., Southfield 48075
Horvath, James J....1553 Woodward Ave., Detroit 48226
Horvitz, Victor S.....18400 Schaefer Hwy., Detroit 48235
Hotchkiss, Loris M.......33220 W. 7 Mile, Livonia 48152
Howard, Philip J.......Henry Ford Hosp., Detroit 48202
Howard, William K..........1800 Tuxedo, Detroit 48206
Howell, Bert F........10800 Whittier Rd., Detroit 48224
Howell, James T.....2799 W. Grand Blvd., Detroit 48202
Howes, Homer A. 1515 Dav. Whitney Bldg., Detroit 48226
Howlett, Howard T.......868 Fisher Bldg., Detroit 48202
Hoyos, Pedro G.....................6085 Campus Dr., Dearborn Hghts. 48127
Hromadko, Louis (L)...1053 Fisher Bldg., Detroit 48202

Hubbard, John P., Jr. (L)........146 E. Seven Mile Rd., Detroit 48205
Huber, Philip J...........1724 Bassett, Royal Oak 48067
Hudson, J. Stewart (L)................319 Fisher Rd., Grosse Pte. 48230
Hudson, Wm. A. (L).....Hudsonakers, Jasper, Ar. 72641
Hudspeth, E. Rae........763 Fisher Bldg., Detroit 48202
Huebl, Hubert C...Detroit Receiving Hosp., Detroit 48226
Huegli, Wilfred A...16840 E. Warren Ave., Detroit 48224
Huggins, H. Horne..........8355 Gratiot, Detroit 48213
Hughes, Calvin H....19959 Vernier, Harper Woods 48236
Hughes, John A...........4407 Roemer, Dearborn 48126
Hughett, Arthur J...19959 Vernier, Harper Woods 48236
Hulick, Archie G............1600 Tuxedo, Detroit 48206
Hull, Leroy W. (L).....6364 Cowell Rd., Brighton 48116
Hullerman, Hugo V.....Children's Hospital, Detroit 48202
Hume, H. Ross, Jr........1553 Woodward, Detroit 48226
Huminski, Thaddeus S.............19244 Van Dyke Ave., Detroit 48234
Hummel, Arthur R.....1020 3 Mile Rd., Grosse Pte. 48236
Hunt, Theodore H...19431 Van Dyke Ave., Detroit 48234
Hunt, Verne G. (L)..1553 Woodward Ave., Detroit 48226
Hunter, Donald G.......3245 E. Jefferson, Detroit 48207
Hunter, Robert B.......Henry Ford Hosp., Detroit 48202
Husband, Chas. W. (L)...........14500 W. McNichols, Detroit 48235
Husband, Raymond C..............14500 W. McNichols, Detroit 48235
Hutchins, M. Colton..3011 W. Grand Blvd., Detroit 48202
Hyatt, Jarvis M.....22340 Michigan Ave., Dearborn 48124
Hyde, Fredk. W., Jr........Grace Hospital, Detroit 48201
Hyland, John R.............17200 Mack, Detroit 48224
Hysni, Aliqemal....8031 W. Vernor Hwy., Detroit 48209
Iacobell, Peter H.........19300 Van Dyke, Detroit 48234
Iacobellis, M......22159 W. Outer Drive, Dearborn 48124
Ice, Garnet T..............18060 Conant, Detroit 48234
Iglesias, Luis J...............3535 W. 13 Mile, No. 507, Royal Oak 48072
Igna, Eli J..........2799 W. Grand Blvd., Detroit 48202
Ignagni, Antonio.........21470 Sloan Dr., Detroit 48236
Imamoglu, Kamil (A)............1400 Chrysler Expwy., Detroit 48207
Indenbaum, Samuel..18400 Schaefer Hwy., Detroit 48235
Ine, Myung Yul............1800 Tuxedo, Detroit 48206
Ingberg, Harry O.............261 Brady, Detroit 48201
Irvin, Earle A...Ford Motor Co. America, Dearborn 48121
Irwin, Wm. A........16001 9 Mile Rd., Southfield 48075
Isaacson, Arthur (L).....18989 San Juan, Detroit 48221
Isaacson, Harold E.....15361 Plymouth Rd., Detroit 48227
Isaacson, Jo. D.......................26008 Pembroke, Huntington Woods 48070
Ishac, F. F.....34715 W. Seven Mile Rd., Livonia 48152
Israel, Barney B.........663 Fisher Bldg., Detroit 48202
Israel, Kenneth......16067 W. 7 Mile Rd., Detroit 48221
Itkin, H. David...........2900 S. Fort St., Detroit 48217
Iwata, Herbert T........7611 Patton Ave., Detroit 48228
Izner, Bernice.............660 Whitmore, Detroit 48203
Izner, Sanford M.....17500 Schaefer Hwy., Detroit 48235
Jacknow, David..........60 W. Hancock, Detroit 48201
Jackson, Franklin R..........2424 Puritan, Detroit 48238
Jackson, Winston B.........2425 Oakman, Detroit 48238
Jacobs, David M.....10601 W. 7 Mile Rd., Detroit 48221
Jacobs, Howard.........18241 Greenfield, Detroit 48235
Jacobson, Lyle F.........5224 St. Antoine, Detroit 48202
Jacobson, Saml. D...Wayne Co. Genl. Hosp., Eloise 48132
Jacobus, Wayne N...20055 Mack Ave., Grosse Pte. 48236
Jaconette, J. R....Mt. Carmel Mercy Hosp., Detroit 48235
Jaeger, Grove A...........11711 Minden, Detroit 48205
Jackel, Clarence N. (L).........1086 E. Grand Blvd., Detroit 48207
Jaffar, Donald J.......671 Fisher Building, Detroit 48202
Jaffe, Harold W...1706 David Whitney Bl., Detroit 48226
Jaffe, Jacob.........2211 Woodward Ave., Detroit 48201
Jaffe, Louis..............18662 Muirland, Detroit 48221
Jahsman, Wm. E. (R)...............1410 Sunset Dr., Clearwater, Fl. 33515
Jakacki, Richard Wm.....36157 Sherwood, Livonia 48154
James, Thomas N......Henry Ford Hosp., Detroit 48202
Jamieson, Thos. J........2058 Ferris, Lincoln Park 48146
Janicki, Natalia J.............Eloise Hosp., Eloise 48132
Jarvis, Harold F..............360 Moross, Detroit 48236
Jasion, Lawrence J. (A).....11945 Payton, Detroit 48224
Jaynes, Richard V.....29901 Ford Rd., Garden City 48135
Jeffries, Benj.....19959 Vernier Rd., Harper Woods 48236
Jend, Wm., Jr............1365 Cass Ave., Detroit 48226
Jenkins, Elwood A.............610 Dav. Whitney Bldg., Detroit 48226
Jennings, Chas. G...356 Hillcrest, Grosse Pte. Farms 48236
Jensen, Viggo W..........17850 Maumee, Detroit 48230
Jevons, William H...8425 Twelve Mile Rd., Warren 48093
Jewell, F. C............7220 Gratiot Ave., Detroit 48213
Jewell, John S...2021 Monroe, Suite 203, Dearborn 48124
Jewell, Marvin R.......Childrens Hospital, Detroit 48202
Jocz, Marion W.........945 Trombley Rd., Detroit 48230
Jodar, Emery O.........15760 Mack Ave., Detroit 48224
Jodar, Loyal W..........18412 Mack, Grosse Pte., 48236
John, Hubert R. (L)..20905 Greenfield, Southfield 48075
Johnson, Aran S.....................642 Blairmoor Ct., Grosse Pte. Woods 48236
Johnson, Arthur J.....Henry Ford Hospital, Detroit 48202
Johnson, Gage............2785 S. Fort St., Detroit 48217
Johnson, Homer L. (R)..648 Collingwood, Detroit 48202
Johnson, Simon O............300 Cadillac Square Bldg., Detroit 48226
Johnson, Thos. D......18530 Grand River, Detroit 48223
Johnson, Verne E.....2051 Monroe Ave., Dearborn 48124
Johnson, Vernon P..................21327 Harper Ave., St. Clair Shores 48080
Johnson, Wilbur E..........14654 Gratiot, Detroit 48205
Johnson, Wm. H. M. (L) 7157 63 Michigan, Detroit 48210
Johnston, Everett V. (L)............30130 Bristol Lane, Birmingham, 48010
Johnston, Herbert C.....3001 Miller Rd., Dearborn 48120
Johnston, J. Peter....Henry Ford Hospital, Detroit 48202
Johnston, Jos. A. (L)...Henry Ford Hosp., Detroit 48202
Johnston, Wm. E. (L)............3011 W. Grand Blvd., Detroit 48202
Johnstone, Benj. I. (L)...555 Fisher Bldg., Detroit 48202
Joinville, Euclide V. (L)..1202 Stroh Bldg., Detroit 48226
Jones, Arnold M..........3706 Sturtevant, Detroit 48206
Jones, G. Richard.......18412 Mack Ave., Detroit 48236
Jones, Roy D. (L).....10234 Puritan Ave., Detroit 48238
Jones, Wm. J..........8209 Allen Rd., Allen Park 48101
Joos, Thad. H........20340 Harper, Harper Woods 48236
Jordan, Prescott, Jr.......5224 St. Antoine, Detroit 48202
Jordan, R. Gerald.......12410 Van Dyke, Detroit 48234
Joseph, Ramon R....Wayne Co. Gen. Hosp., Eloise 48132
Joyce, Stanley J.........1078 Fisher Bldg., Detroit 48202
Joyrich, Myron H..........Sinai Hospital, Detroit 48235
Juliar, Benj..........17305 Muirland Ave., Detroit 48221
Juliar, Joseph F...........17526 Oak Dr., Detroit 48221
Juncker, John B.........Oakwood Hosp., Dearborn 48124
Jungwirth, R. V...19350 W. McNichols Rd., Detroit 48219
Kackley, James E............18495 Mack, Detroit 48236
Kain, Thomas R...1400 Chrysler Exp. Way, Detroit 48207
Kaine, Henry D......3011 W. Grand Blvd., Detroit 48202
Kalayjian, Bernard S...30676 Harlincin Ct., Franklin 48025
Kalichman, Nathan.......19304 Wyoming, Detroit 48221
Kallenbach, Rudolph W....388 Inkster Rd., Inkster 48141
Kallet, Herbert I. (L)....651 Fisher Bldg., Detroit 48202
Kallet, Maerit B.............1800 Tuxedo, Detroit 48206
Kallman, David (L)..2351 W. Grand Blvd., Detroit 48208
Kallman, Leo.......2351 W. Grand Blvd., Detroit 48208
Kallman, Reuben R...2631 Woodward Ave., Detroit 48201
Kambouris, Angelow A.........744 Dav. Whitney Bldg., Detroit 48226
Kamil. Richard S........14438 McNichols, Detroit 48235
Kandel, Robert F.......Henry Ford Hosp., Detroit 48202
Kane, Archibald V............Box 1108, Northland Ctr., Southfield 48075
Kansa, Selma...........19431 Van Dyke, Detroit 48234
Kantor, Sheldon M.........19207 Schaefer, Detroit 48235
Kapetansky, Don I........17376 Schaefer, Detroit 48235
Kapetansky, Nathan J.......17376 Schaefer, Detroit 48235
Kaplita, Walter A...................60 Fontana Lane, Grosse Pte. Shores 48236
Kapphahn, K. H........Henry Ford Hosp., Detroit 48202
Kaprielain, M....15800 W. McNichols Rd., Detroit 48235
Karadeloglou, B.........817 Virginia Park, Detroit 48202
Karamatas, Philip C...10822 W. Warren, Dearborn 48126
Karch, Saul..............18080 Muirland, Detroit 48221
Kargas, A. K......Wayne Co. General Hosp., Eloise 48132

Kasabach, Harry Y...1553 Woodward Ave., Detroit 48226
Kasabach, Vahram Y.....1814 Book Tower, Detroit 48226
Kashtan, Harry A.....15201 W. McNichols, Detroit 48235
Kasper, Jos. A. (L)..................1011 Cadieux Rd., Grosse Pte. Park 48230
Kaspor, Albert J........20901 Moross Rd., Detroit 48236
Kass, Arnold......1316 David Stott Bldg., Detroit 48226
Katz, Lawrence..........987 E. Jefferson, Detroit 48207
Katz, Martin.......12794 Veronica Dr., Southgate 48192
Katzman, Irving S..........412 Fox Bldg., Detroit 48201
Kaufman, Jack H........17421 Greenfield, Detroit 48235
Kaufman, Louis W...10326 W. Seven Mile, Detroit 48221
Kaufman, William H.............10149 Michigan Ave., Dearborn 48126
Kawchak, James.......Ford Motor Co., Dearborn 48121
Kawecki, Lucian.....................10734 Hart Ave., Huntington Woods 48070
Kawel, Conrad A., Jr..............10955 Farmington Rd., Livonia 48150
Kazdan, Morris.......4619 Allen Road, Allen Park 48101
Keemer, Edgar B., Jr.....8256 Grand River, Detroit 48204
Kehoe, Henry J........15252 Gratiot Ave., Detroit 48205
Keith, Rachel H. C. B.......5050 Joy Rd., Detroit 48204
Kelin, Maximilian..................18691 Mark Twain, Detroit 48235
Kelley, Frank J..........853 Fisher Bldg., Detroit 48202
Kelly, A. P., Jr.........Henry Ford Hosp., Detroit 48202
Kelly, Edward W., Jr......156 Harmon St., Detroit 48202
Kelly, John J.........14729 Champaign, Allen Park 48101
Kelly, L. J.................14015 Gratiot, Detroit 48205
Kelmenson, Victor A........7356 12th St., Detroit 48206
Kelson, Malcolm J...........1045 Harvard, Detroit 48230
Kennary, James M......4900 Cadieux Rd., Detroit 48224
Kennary, James M., Jr...4900 Cadieux Rd., Detroit 48224
Kennedy, Donald J.......9000 E. Jefferson, Detroit 48214
Kermath, James E.....15101 Southfield, Allen Park 48101
Kernick, Melvin O..............13700 Woodward Ave., Highland Park 48203
Kerwin, George R...22149 Chatsford Cir., Southfield 48075
Kessel, Karl J........21421 Kelly Rd., East Detroit 48224
Kessler, Chas.............18241 Greenfield, Detroit 48235
Keyes, John W.........Henry Ford Hosp., Detroit 48202
Kilar, Theodore W.................31815 Southfield Rd., Birmingham 48009
Killins, Chas. G.........8100 E. Jefferson, Detroit 48214
Kimberlin, K. K., Jr...11110 Morang Drive, Detroit 48224
King, Edward D. (L)........5455 W. Vernor Highway, Detroit 48209
King, Melbourne J...5435 W. Vernor Hwy., Detroit 48209
Kingswood, Roy C. (L)...........14310 Hamilton Ave., Highland Park 48203
Kitzmiller, John L............15800 W. McNichols Ave., Detroit 48235
Klaiber, Roger G........1541 Edsel Drive, Trenton 48183
Klein, Herman.......5030 Wallbrook, Birmingham 48010
Klein, Howard A.............1846 Dav. Whitney Bldg., Detroit 48226
Klein, Sander P...14825 W. McNichols Rd., Detroit 48235
Klein, Wm. (A)..........13965 Linwood, Detroit 48238
Kleinman, Shmarya (L).....1800 Tuxedo, Detroit 48206
Klicka, Karl S.............33101 Annapolis, Wayne 48184
Kliger, David (L).........7756 Southfield, Detroit 48228
Klimchuk, M. M.....22770 Kelly Rd., East Detroit 48021
Klimkowski, Edw. J............17301 W. Eight Mile Rd., Detroit 48235
Kling, George A. (M)....Harper Hospital, Detroit 48201
Kling, Murray G.....22341 W. Eight Mile, Detroit 48219
Klosowski, Jos. (R)..8222 E. Outer Drive, Detroit 48213
Kluck, Clarence J.......25210 Grand River, Detroit 48240
Klutke, Geo. H. E.........2841 Monroe, Dearborn 48124
Knaggs, Earl J..........2387 Fort St., Wyandotte 48192
Knapp, Floyd B. (R)....................Box 468, R. 1, Houghton Lake 48629
Knapp, Gary H............23611 Goddard, Taylor 48180
Knapp, Gordon R. (R)..422 W. Goldengate, Detroit 48203
Knapp, Wm. L...27740 Devonshire Dr., Southfield 48075
Knighton, Robt. S...2799 W. Grand Blvd., Detroit 48202
Knobloch, Edmund J. (L)..5933 Chene St., Detroit 48211
Knopf, Merrill M. (A)..........Detroit Receiving Hosp., Detroit 48226
Knott, Stuart A...........100 Oak St., Wyandotte 48192

Knox, Ross M.........3180 Fort St., Lincoln Park 48146
Kobernick, Sidney D.....6767 W. Outer Dr., Detroit 48235
Kobiljak, Stefan H...3516 Fort Street, Lincoln Park 48146
Kobold, Elmer E.................Detroit General Hosp., Detroit 48226
Kochkodan, Eugene J....15520 Garfield, Allen Park 48101
Koebel, Raymond H.................409 N. Shore Dr., St. Clair Shores 48080
Koek, Hans J.........23100 Cherry Hill, Dearborn 48124
Koerber, Edward J....4876 Lakeview Ave., Detroit 48215
Kogan, Natalio.............Sinai Hospital, Detroit 48235
Kogut, Constantine S.......10627 Puritan, Detroit 48238
Kokowicz, Raymond J.....19440 Van Dyke, Detroit 48234
Kolman, Isadore I...........1800 Tuxedo, Detroit 48206
Komisaruk, Richard.....1575 E. Lafayette, Detroit 48207
Kondomerkos, John D...33020 Palmer Road, Wayne 48184
Kong, Leighton N. L.........Grace Hosp., Detroit 48201
Kopf, George M. (A)............Detroit General Hosp., Detroit 48226
Kopmeyer, Joe M., Jr.....17632 Grandville, Detroit 48219
Koran, Valentine L.......1306 Kales Bldg., Detroit 48226
Koren, Louis......1300 Cadillac Sq. Bldg., Detroit 48226
Kornacki, Thomas E.............719 New Center Bldg., Detroit 48202
Korum, Lyle W.......18585 E. Warren St., Detroit 48236
Koschnitzke, H. K.....15101 Southfield, Allen Park 48101
Kossayda, Adam W...............15324 Michigan Ave., Dearborn 48126
Kovach, Emery P.........9750 Chalmers, Detroit 48213
Kovan, Dennis D..................16965 Hamilton Ave., Highland Park 48203
Kowaleski, John J.......12789 Veronica, Southgate 48192
Kozlinski, Anthony E...2195 E. Grand Blvd., Detroit 48211
Krabbenhoft, K. L.........3825 Brush St., Detroit 48201
Kraft, Raymond B. (R).............700 S. Ocean Blvd., Boca Raton, Fl. 33432
Kraft, Ruth M...19164 Devonshire Rd., Birmingham 48009
Krakauer, Bernard...........17716 W. Seven Mile Rd., Detroit 48235
Krass, Edward W.......11088 Gratiot Ave., Detroit 48213
Kraus, John J.......16840 E. Warren Ave., Detroit 48224
Krawec, Charles J.............Mt. Carmel Mercy Hosp., Detroit 48235
Krebs, Wm. T.......16419 E. Warren Ave., Detroit 48224
Kreinbring, Geo. E....14295 E. 7 Mile Rd., Detroit 48205
Kretzschmar, John C...660 E. Grand Blvd., Detroit 48207
Krevsky, David A...........8449 Park, Allen Park 48101
Krevsky, Harold......8449 Park Avenue, Allen Park 48101
Krieg, Earl G. (A)..757 Middlesex, Grosse Pte. Park 48236
Krieger, Harvey L. (R)..11390 Strathmoor, Detroit 48227
Kristen, Karl T...Mt. Carmel Mercy Hosp., Detroit 48235
Kritchman, Maurice J.....10 Witherell St., Detroit 48226
Kroha, Lawrence A...15124 Kercheval Ave., Detroit 48230
Krohn, Lawrence H...........24340 W. McNichols Rd., Detroit 48219
Kroll, Harvey V.........7815 E. Jefferson, Detroit 48214
Krull, Edward A.....482 Rivard Blvd., Grosse Pte. 48230
Krynicki, Francis X.......15101 W. 7 Mile, Detroit 48235
Krystal, Henry..............19210 Coyle, Detroit 48235
Kubanek, Jos. L. (L).....23134 Myrtle, Dearborn 48128
Kucmierz, Francis S...18934 Van Dyke Ave., Detroit 48234
Kuehn, Ned N...20203 Wellesley Blvd., Birmingham 48010
Kuhn, Albert A.....635 W. Seven Mile Rd., Detroit 48203
Kuhn, Henry H.....635 W. Seven Mile Rd., Detroit 48203
Kuhn, Richard F.......1700 Junction Ave., Detroit 48209
Kujawski, Walter F............17800 E. Eight Mile Rd., Detroit 48236
Kullman, Harold J. (A)..930 Beechmont, Dearborn 48124
Kuran, Lionel V........14853 Michigan, Dearborn 48126
Kurcz, Jos. A.........7433 Michigan Ave., Detroit 48210
Kurtz, Irvin J..........25210 Grand River, Detroit 48240
Kurtzman, Raymond S...........Detroit Memorial Hosp., Detroit 48226
Kutsche, John D............3794 Fort St., Trenton 48183
Kvietys, Benj.............27235 Joy Rd., Dearborn 48127
Kwasiborski, S. A........2300 Oak St., Wyandotte 48192
Kyle, Wm. V., Jr...........4741 Spokane, Detroit 48204
Laberge, James M............100 Oak, Wyandotte 48192
Lackey, Lawrence S.............525 Visger, Ecorse 48229
Laderach, David C.........1704 Iroquois, Detroit 48214
Lafata, Philip J.........15260 Levan Rd., Livonia 48154

La Ferte, Alfred D. (L)..520 St. Clair, Grosse Pte. 48230
Laham, M. M............2929 Fort St., Wyandotte 48192
Lahood, Michael J.......20001 Greenfield, Detroit 48235
Laige, Raymond J. (A).....P.O. Box 1259, Detroit 48231
Lajoie, Louis J..............601 Piquette, Detroit 48202
Lakatos, George C...........33020 Palmer, Wayne 48184
Lake, Robt. C...........8445 E. Jefferson, Detroit 48214
Lakin, Alan C...10326 W. Seven Mile Rd., Detroit 48221
Lakin, Mervyn H.....17555 James Couzens, Detroit 48235
Lakoff, Chas. B. (L)............8233 W. Chicago Blvd., Detroit 48204
Lam, Conrad R...28130 Westbrook Ct., Farmington 48024
Lamberson, Frank A....19001 Grand River, Detroit 48223
Lammy, James V...748 Dav. Whitney Bldg., Detroit 48226
Lamont, Richard L.....3815 Pelham Rd., Dearborn 48124
Lamontagne, Gaetan.....15830 Fort St., Southgate 48192
Lampman, Harold H. (L)........3011 W. Grand Blvd., Detroit 48202
Landers, Maurice B...275 W. Grand Blvd., Detroit 48216
Lang, Ernst F...........3790 Woodward, Detroit 48201
Lange, Wm. A.......3790 Woodward Ave., Detroit 48201
Langston, John D.....1420 St. Antoine St., Detroit 48826
Laning, Geo. M. (L)..R. D. Morey Rd., Sharon, Ct. 06069
Lansing, Eugene H......33020 Palmer Rd., Wayne 48184
Lansky, Mandell........16339 E. Warren, Detroit 48224
Large, Alfred M...701 Dav. Whitney Bldg., Detroit 48226
Largo, Donald J...........16717 Warwick, Detroit 48219
Larkin, Duane R.........28435 Plymouth, Livonia 48150
Larned, Richard I.........15208 Bringard, Detroit 48205
Larsen, Edward G......1803 Trenton Dr., Trenton 48183
Larsen, Robt. D........76 W. Adams Ave., Detroit 48226
Larson, Chas. J......12729 Cunningham, Southgate 48192
Larson, Francine S...18865 Haggerty Rd., Northville 48167
Larsson, Bror H. (L)....81 E. Kirby Ave., Detroit 48202
Lasichak, Andrew G....76 W. Adams Ave., Detroit 48226
Lasley, James W...1014 David Whitney Bl., Detroit 48226
Latimer, Fredk. R..........28 W. Adams, Detroit 48226
Latteier, Karl K.....15025 W. 8 Mile Rd., Detroit 48235
Lauppe, Edward H...1553 Woodward Ave., Detroit 48226
Lauppe, Fredk. A....1553 Woodward Ave., Detroit 48226
Laura, Albert L...........9105 Harrison, Livonia 48150
Laurisin, Eugene (L)........3019 W. 13 Mile, Apt. 413, Royal Oak 48073
Lauter, Eric W.............1800 Tuxedo, Detroit 48206
Lawand, Frank K.............952 David Whitney Bldg., Detroit 48226
Lawhead, Nixon R. (L)...19150 Kelly Rd., Detroit 48236
Lawrence, Louis F.....17300 Schaefer Rd., Detroit 48235
Lawson, John W. (A)..98 Hazlewood Ave., Detroit 48202
Lazar, Morton R.......20905 Greenfield, Southfield 48075
Leach, David............430 Fisher Bldg., Detroit 48202
Leach, Robt. B...........1401 Rivard St., Detroit 48207
Leach, Wendell L.......10811 E. Warren, Detroit 48214
Leacock, Robt. C.....440 University Pl., Grosse Pte. 48236
Leader, Luther R. (L)...........3535 W. 13 Mile Rd., Royal Oak 48072
Leaver, L. Ross.......757 Lakewood Ave., Detroit 48215
Lebamoff, Alexander T...7940 Allen Rd., Allen Park 48101
Lechner, Monroe S...22770 Kelly Rd., East Detroit 48021
Lecklider, A. F. (R)..848 Berkshire Rd., Grosse Pte. 48230
Lee, Frank........501 Meadowlane Dr., Dearborn 48124
Lee, Harry E. (L)....13616 Gratiot Ave., Detroit 48205
Lee, Pyong Tai....15901 W. 9 Mile Rd., Southfield 48075
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Lehmann, Robert N.............26029 W. Five Mile Rd., Detroit 48239
Leipsitz, Louis S..........3566 Cass Ave., Detroit 48201
Leiter, Forrest C..........2355 Monroe, Dearborn 48124
Leithauser, Danl. J. (L)........432 Eastland Prof. Bldg., Detroit 48236
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Lemon, Bruce K.......20905 Greenfield, Southfield 48075
Lentine, James J........15831 Mack Ave., Detroit 48224
Lentz, Conrad L. (A)......19716 Schaefer, Detroit 48235
Lenz, Willard R...........418 Moran Rd., Detroit 48236
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Lepley, Fred O. (L)................19799 Mack Ave., Grosse Pte. Woods, 48236
Lepley, Frederick J.......19803 Mack, Grosse Pte. 48236
Lerman, Saml. I...........18330 Parkside, Detroit 48221
Lerner, Leonard H.............7310 W. Seven Mile Rd., Detroit 48221
LeRoy, George V............1800 Tuxedo, Detroit 48206
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Leslie, C. G.............8401 Woodward, Detroit 48202
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Levant, Arthur B........15715 E. Warren, Detroit 48224
Levenson, Malcolm L......24500 Custis, Southfield 48075
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Levick, Walter G....19959 Vernier, Harper Woods 48236
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Levin, M. Mitchell....20905 Greenfield, Southfield 48075
Levin, Saml. J.......3011 W. Grand Blvd., Detroit 48202
Levine, Edward E...................12891 Sherwood, Huntington Woods 48070
Levitt, Irving........24535 N. Carolina, Southfield 48075
Levitt, Nathan (L).......607 Kales Bldg., Detroit 48226
Levy, David B.............29586 Fenkell, Livonia 48151
Levy, Marvin B...23200 Woodward Ave., Ferndale 48220
Levy, Stanley H.....10601 Seven Mile Rd., Detroit 48221
Lewin, Harry (L)...27012 Knob Woods, Southfield 48075
Lewis, Benjamin M...........1401 Rivard, Detroit 48207
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Lewis, Harvey Y...14219 W. McNichols Rd., Detroit 48235
Lewis, J. Hugh........1543 Ford Ave., Wyandotte 48192
Lewis, Lee A.......2730 E. Jefferson Ave., Detroit 48207
Lewis, Robt. H....17401 Roseland, Lathrup Village 48075
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Licht, Robert..........6071 W. Outer Dr., Detroit 48235
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Liddicoat, Arthur G. (L)....20125 Fenkell, Detroit 48223
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Lilly, Robert P...29594 W. Five Mile Rd., Livonia 48154
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Lipkin, Ezra (L).....5715 Michigan Ave., Detroit 48210
Lipnik, Carl E..........31610 Plymouth Rd., Livonia 48150
Lipnik, Morris J...17000 W. Eight Mile, Southfield 48075
Lipschutz, Louis S...19750 Chesterfield Rd., Detroit 48221
Lipson, Channing T...20101 James Couzens, Detroit 48235
Lipson, Madeleine L.........1800 Tuxedo, Detroit 48206
Lipton, Raymond F.......10 Peterboro St., Detroit 48201
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Loomus, Gerald N.....4100 W. McNichols, Detroit 48221
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Lorber, Jos. H.........873 Lakewood Ave., Detroit 48215
Lorentzen, Edwin H. (L).......11702 Grand River Ave., Detroit 48204
Lovas, Wm. S.........3577 Fort St., Lincoln Park 48146
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Love, James M..........16565 Bentler St., Detroit 48219
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Lynn, David H.......Lynn Hospital, Lincoln Park 48146
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Markey, Frank R..........17174 Fairfield, Detroit 48221
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Marshall, James R. (L).........14827 E. Jefferson Ave., Detroit 48215
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Martin, Peter A.........857 Fisher Bldg., Detroit 48202
Martin, Walter..........13800 Livernois, Detroit 48238
Martin, Wilbur C.......10401 W. Chicago, Detroit 48204
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Martinez, Pedro O.......1439 Bagley Ave., Detroit 48216
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Marvin, Robert C.........22362 Morley, Dearborn 48124
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Matthews, Burton V...13724 W. Fort St., Southgate 48192
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McClelland, Rachael L.............33026 Five Mile Rd., Livonia 48154
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McCue, Francis B......7106 Park Ave., Allen Park 48101
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McDonald, Angus L. (L)....15125 Gratiot, Detroit 48205
McDonald, John R..........Harper Hosp., Detroit 48201
McDonald, Wm. G. 15600 Michigan Ave., Dearborn 48126
McEvitt, Wm. G.....1140 W. Boston Blvd., Detroit 48202
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McGough, Jos. M......18716 Grand River, Detroit 48223
McGuire, John F..........3815 Pelham, Dearborn 48124
McHenry, John T.........1401 Rivard St., Detroit 48207
McHenry, Martin.....Henry Ford Hospital, Detroit 48202
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McIntyre, Wm. B.............1145 Dav. Whitney Bldg., Detroit 48226
McKean, G. Thos....1553 Woodward Ave., Detroit 48226
McKeever, Geo. E...5237 Oakman Blvd., Dearborn 48126
McKenna, Chas. J........14618 E. 7 Mile, Detroit 48205
McKinney, Roy J....719 New Center Bldg., Detroit 48202
McKnight, Robt. E.....20905 Greenfield, Southfield 48075
McLane, Harriet I. E. (L)..........4350 Oregon Ave., Detroit 48204
McLaurin, Jasper E.........5050 Joy Rd., Detroit 48204
McLean, Brita R...............1365 Cass, Detroit 48226
McLean, Don W........1066 Fisher Bldg., Detroit 48202
McLean, Donald C.......459 Fisher Bldg., Detroit 48202
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McNeill, Roger F.......119 Kercheval, Grosse Pte. 48236
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Melnik, Maxim P.....3011 W. Grand Blvd., Detroit 48202
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Meyer, John S.........Wayne State Univ., Detroit 48207
Meyer, Kenneth R.......Oakwood Hosp., Dearborn 48124
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Meyers, Maurice P........18984 Livernois, Detroit 48221
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Mikhail, George.......Henry Ford Hosp., Detroit 48202
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Miller, Antonina.......16989 Farmington, Livonia 48154
Miller, Danl. H.......23100 Cherry Hill, Dearborn 48124
Miller, Elmer B...7 John Glenn Place, Highland Park 48203
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Miller, Jacob J.......20131 James Couzens, Detroit 48235
Miller, Martin J......2799 W. Grand Blvd., Detroit 48202
Miller, Jose W...........Childrens Hosp., Detroit 48202
Miller, Karl L.......1553 Woodward Ave., Detroit 48226
Miller, Myron H. (L).............27330 Southfield Rd., Lathrup Village 48075
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Mills, Clinton C...16190 Jas. Couzens Hwy., Detroit 48221
Mills, Geo. R........8209 Allen Road, Allen Park 48101
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Mines, Robert E., Jr. (M)........8401 Woodward Ave., Detroit 48202
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Moss, Norman D.......28233 Tapert Dr., Southfield 48075
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Nill, Wm. F. (L)........15001 E. Warren, Detroit 48224
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Nyboer, Jan.............Harper Hospital, Detroit 48201
O'Brien, Geo. M...18239 W. Seven Mile Rd., Detroit 48219
O'Bushkevich, Leon S...15720 W. Warren, Detroit 48228
O'Connor, Katheryn L....17711 Schoolcraft, Detroit 48227
O'Donnell, Dayton H.....22000 Greenfield, Detroit 48237
O'Donnell, Eugene P.......3700 West Rd., Trenton 48183
Oetting, Edward M.....1041 Whittier, Grosse Pte., 48236
O'Gawa, Gilbert M.....Henry Ford Hosp., Detroit 48202
Ohmart, Galen B. (L)...........8721 E. Jefferson Ave., Detroit 48214
Ohorodnik, Julius M...Bon Secours Hospital, Detroit 48230
Okun, Milton H.....3261 Sherbourne Rd., Detroit 48221
Oldford, Joseph R...17000 W. 8 Mile Rd., Southfield 48075
Olejniczak, Stanley..........Wayne County Gen Hosp., Eloise 48132
Olen, Alex............13100 Harper Ave., Detroit 48213
O'Linn, Francis P........1055 Fisher Bldg., Detroit 48202
Olmsted, Geo. S...27305 Southfield, Lathrup Village 48075
Olson, Avis M.....Mt. Carmel Mercy Hosp., Detroit 48235
Olson, Donald T...17701 W. McNichols Rd., Detroit 48235
Olson, George P...........Chrysler Corp., Detroit 48235
Olson, James A...17000 West 8 Mile Rd., Southfield 48075
Olsztyn, Stanley R.....10801 W. Warren, Dearborn 48126
Oppenheim, Jos. M.........24091 Dante, Oak Park 48237
Ormond, Robt. S.........1951 Monroe St., Dearborn 48124
O'Rourke, Paul V.........2635 Woodstock, Detroit 48203
O'Rourke, Randall M.........7384 12th St., Detroit 48206
Ortiz, Armando..............610 Northland Med. Bldg., Southfield 48075
Osius, Eugene A...901 Dav. Whitney Bldg., Detroit 48226
Ostrowski, Arthur Z...........610 Northland Med. Bldg., Southfield 48075
Otlewski, Eugene A....20905 Greenfield, Southfield 48075
Ottaway, John P.......................18226 Mack Ave., Grosse Pte. Farms 48236
Otto, Donald.....Det. Memorial Hospital, Detroit 48226
Owen, Clarence I. (L).................2689 Dupont, Jacksonville, Fl. 32217
Palmer, Alice E...810 Dav. Whitney Bldg., Detroit 48226
Palmer, Milton R.......8700 Dexter Blvd., Detroit 48206
Palmisano, I. J.........25447 Plymouth Rd., Detroit 48239
Panczak, Tamara..Plymouth State Hosp., Northville 48167
Panic, Stephen M.....1001 W. Seven Mile, Detroit 48203
Pantos, Theo. G...1536 Dav. Whitney Bldg., Detroit 48226
Parejo, Jose M...........4342 W. Vernor, Detroit 48209
Parfanowycz, S. N. (A)....3347 Grant St., Detroit 48212
Parker, Benj. R...19149 W. Seven Mile Rd., Detroit 48219
Parnagian, Leo..........868 Fisher Bldg., Detroit 48202
Parnell, John W.....................21 Whitcomb Dr., Grosse Pte. Farms 48236
Parr, Robt. W. (A)..1126 Audubon Rd., Grosse Pte. 48230
Parrish, Rufus H. (A).....2610 Sturtevant, Detroit 48206
Pasternacki, N. T..........6203 Chene St., Detroit 48211
Pastorius, Melvin K.......22835 Wilson, Dearborn 48128
Patton, Roy B..........Henry Ford Hosp., Detroit 48202
Paul, Lloyd J............19321 Greenfield, Detroit 48235
Pawlowski, Jerome I. (L)..........2009 E. Grand Blvd., Detroit 48211
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Payne, Walter A., Jr.....283 Hillcrest, Grosse Pointe 48236
Paysner, Harry A...............13700 Woodward Ave., Highland Park 48203
Pearce, Arthur J......26491 Carol, Franklin Village 48025
Pearlman, Jack..25860 Concord, Huntington Woods 48070
Pearse, Harry A...17000 W. Eight Mile, Southfield 48075
Pedersen, Herbert E....3815 Pelham Rd., Dearborn 48124
Peggs, Geo. F.........5419 Livernois Ave., Detroit 48210
Peisojovich, M. (A)........Grace Hospital, Detroit 48201
Pendy, Geo. V...1001 Dav. Whitney Bldg., Detroit 48226
Pendy, John M....1001 David Whitney Bl., Detroit 48226
Penner, David A.......18530 Grand River, Detroit 48223
Pensler, Leslie..........10151 Michigan, Dearborn 48126
Pensler, Meyer.....10151 Michigan Ave., Dearborn 48126
Percy, Donald F.....15901 Greenfield Ave., Detroit 48227
Perdue, Grace M.....3011 W. Grand Blvd., Detroit 48202
Perez-Gurri, Jose L.......3150 Carpenter, Detroit 48212
Perkin, Frank S.....3011 W. Grand Blvd., Detroit 48202
Perlis, Hyman L. (L).......10 Peterboro, Detroit 48201
Perlis, Marvin S.......1030 Fisher Bldg., Detroit 48202
Perry, Harold...............Sinai Hosp., Detroit 48235
Perry, Joseph H......259 Lewiston Rd., Grosse Pte. 48236
Petermann, Claus............1900 Dav. Broderick Twr., Detroit 48226
Peters, Wm. R.....12400 E. Seven Mile Rd., Detroit 48205
Peterson, Gustav..............Fisher Body, Willow Run, Ypsilanti 48197
Peterson, Robert A.....18700 Meyers Rd., Detroit 48235
Petix, Saml. C............19207 Schaefer, Detroit 48235
Petoskey, Edward A.........5656 W. Fort, Detroit 48209
Petrick, Thos. J.......15101 Southfield, Allen Park 48101
Petrini, Mario A.........1080 Fisher Bldg., Detroit 48202

Petrucco, Louis A.........15400 Plymouth, Detroit 48227
Petty, Thos. A...17300 E. Jefferson Ave., Grosse Pte. 48236
Petz, Arthur John....36000 Five Mile Rd., Livonia 48154
Petz, Thomas J...1139 Dav. Whitney Bldg., Detroit 48226
Peven, Philip S.........18709 Meyers Rd., Detroit 48235
Phillips, Burton E...........5050 Joy Rd., Detroit 48204
Picard, Jos. D.......5237 Oakman Blvd., Dearborn 48126
Piccone, Louisa I.......17700 W. Warren, Detroit 48228
Pichette, J. Walton..6650 Greenfield Rd., Dearborn 48126
Pickard, Orlando W. (L)..........14300 W. McNichols, Detroit 48235
Pickard, Sol D.........Henry Ford Hosp., Detroit 48202
Pickering, L. M.........15830 Fort St., Southgate 48192
Pierce, James M., Jr...Wayne St. University, Detroit 48202
Pietraszewski, A. W. (L)........10338 Joseph Campau, Detroit 48212
Piligian, John T...........3825 Brush St., Detroit 48201
Pingel, James F..........998 Norfolk, Birmingham 48009
Pink, Rose M.......11413 Joseph Campau, Detroit 48212
Pino, Ralph H. (L)...........48151 W. Ann Arbor Rd., Plymouth 48170
Piper, Ralph R...........1495 McKinstry, Detroit 48209
Pittman, John E. (L)............1553 Woodward Ave., Detroit 48226
Pitts, Kenneth E........600 Middlesex, Grosse Pte. 48236
Platz, Carol K.....612 Est. Cen. Prof. Bldg., Detroit 48236
Pliskow, Harold..10730 W. Seven Mile Rd., Detroit 48221
Plotnick, Harold..........18654 Muirland, Detroit 48221
Plous, Eugene I..........569 Fisher Bldg., Detroit 48202
Podolsky, Harold M.......3755 Fort, Lincoln Park 48146
Pogrebniak, A.........25210 Grand River, Detroit 48240
Poim, Senta V...............10 Peterboro, Detroit 48201
Polentz, Chas. P.....31815 Southfield, Birmingham 48009
Polk, John E...............8721 12th St., Detroit 48206
Pollack, Jerome L.....14551 Southfield, Allen Park 48101
Pollack, John J...........18200 Wyoming, Detroit 48221
Pollard, R. J.................Grace Hosp., Detroit 48201
Pollens, Louis S...12730 W. McNichols Rd., Detroit 48235
Pollina, Clement J...21503 Harper, St. Clair Shores 48080
Ponka, Jos. L........2799 W. Grand Blvd., Detroit 48202
Pool, Walter D.........20901 Moross Rd., Detroit 48236
Poos, Edgar E. (L)..3001 W. Grand Blvd., Detroit 48202
Pope, Gerald........Henry Ford Hospital, Detroit 48202
Porretta, Chas. A............507 Northland Med. Bldg., Southfield 48075
Porretta, Francis S................18591 Saratoga Blvd., Lathrup Village 48075
Porretta, George F.....20905 Greenfield, Southfield 48075
Porter, Fredk. G.........29590 Five Mile, Livonia 48154
Porter, Howard J. (A)..General Delivery, Romulus 48174
Portnoy, Harry...........18010 Roselawn, Detroit 48221
Posch, Jos. L.........1410 Kales Bldg., Detroit 48226
Posner, Irving........18111 Muirland Ave., Detroit 48235
Postigo, Julio C.......275 W. Grand Blvd., Detroit 48216
Potts, Elihue B...............7404 Dexter, Detroit 48206
Potts, Maurice B. (A)........Grace Hosp., Detroit 48201
Poznanski, Andrew K...Henry Ford Hospital, Detroit 48202
Pracher, John R........3815 Pelham Rd., Dearborn 48124
Prasad, Ananda S...Wayne State University, Detroit 48207
Prasad, Prem S....41001 W. 7 Mile Rd., Northville 48167
Pratt, Jean P. (L)....18910 Fairway Dr., Detroit 48221
Pratt, Lawrence A. (A)............U.S. A.I.D. P.H. E., A.P.O. 96243, San Francisco, Ca.
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Price, A. Hazen (L)..18605 Birchcrest Ave., Detroit 48221
Price, Alvin E.......1553 Woodward Ave., Detroit 48226
Price, Scott K...........Oakwood Hosp., Dearborn 48124
Priest, Robt. J..........Henry Ford Hosp., Detroit 48202
Prince, Addison E............8942 Dexter, Detroit 48206
Prisbe, Edward J.....16603 Plymouth Rd., Detroit 48227
Priver, Julien..........6741 W. Outer Dr., Detroit 48235
Procailo, Alexander B...29901 Ford Rd., Garden City 48135
Proctor, J. Laurence (A).......... ...5935 Middlesex, Dearborn 48126
Proctor, Leonard R.....3815 Pelham Rd., Dearborn 48124
Proctor, Lorne D.......Henry Ford Hosp., Detroit 48202
Prokop, Frank P...12740 S. Marrow St., Dearborn 48126
Prokopowycz, V. (A).......19666 Conant, Detroit 48234
Proskey, Aloysius J. (A)............16167 Glastonbury, Detroit 48219
Proud, Russel F...26151 Huron River Dr., Flat Rock 48134

Prus, A. Michael......4160 John R Street, Detroit 48201
Prust, Frank W.............1536 David Whitney Bldg., Detroit 48226
Prystowsky, S...............1800 Tuxedo, Detroit 48206
Przybylski, Thom. J.......770 Fisher Bldg., Detroit 48202
Pugh, Howard C.....1553 Woodward Ave., Detroit 48226
Pugliesi, Angelo........9489 E. Outer Dr., Detroit 48213
Pugliesi, Benedetto (L)..9489 E. Outer Dr., Detroit 48213
Purcell, Frank H. (L)....10 Witherell St., Detroit 48226
Puro, Henry E..........1733 Trenton Dr., Trenton 48183
Pursel, Stewart E........1016 Prof. Plaza, Detroit 48201
Purves, W. L...............17595 Parkside, Detroit 48221
Quennell, W. L. (A)................3006 Theresa Dr., c/o Wm. McTwigan, Newburg Park, Ca. 91320
Quigley, Eugene H......111 Brentwood, Dearborn 48124
Quigley, Wm. G.........1075 Fisher Bldg., Detroit 48202
Quinn, Edward L......1141 Golfview, Birmingham 48009
Quinones, Rafael E........17200 E. Warren, Detroit 48224
Rabinovitch, Bella M.......20133 Marlowe, Detroit 48235
Raby, Naim M...............15830 Fort, Southgate 48192
Rachmaninoff, N...........Harper Hosp., Detroit 48201
Radgens, Paul D. (A).....16576 Warwick, Detroit 48219
Ragheb, Samir...........4407 Roemer, Dearborn 48126
Rahm, Lambert P...14411 E. Jefferson Ave., Detroit 48215
Raiford, Frank P., Jr.........9107 12th St., Detroit 48206
Ralyea, Imbi.......22700 Garrison 1103, Dearborn 48124
Ramos, Benjamin R.............17107 Mt. Vernon Blvd., Southfield 48075
Ramos, Herminio R.......9801 Conant, Hamtramck 48212
Ramsey, Robt. H...........3815 Pelham, Dearborn 48124
Randall, David S.......3955 Fort St., Lincoln Park 48146
Rapoport, Bernard..........1800 Tuxedo, Detroit 48206
Rapp, Seymour L...22711 Wrexford Dr., Southfield 48075
Raskin, Herbert A.....18510 Meyers Road, Detroit 48235
Rastello, Peter B. (R)............3295 West Shore Dr., Orchard Lake 48033
Rattner, Wm. H...1355 Dav. Whitney Bldg., Detroit 48226
Rau, Fredk. W......3790 Woodward Ave., Detroit 48201
Raven, Clara............400 E. Lafayette, Detroit 48226
Ravin, Herbert A.......6767 W. Outer Dr., Detroit 48235
Ravitz, Louis A........23350 Thorncliff, Southfield 48075
Ray, Kenneth J........28059 Elba Dr., Grosse Ile. 48138
Raynor, Harold F. (L)....49 Virginia Pk., Detroit 48202
Razi, Massoud............1214 S. Wayne, Wayne 48184
Rebandt, Raymond W...2615 W. Jefferson, Trenton 48183
Rebuck, John W.....2799 W. Grand Blvd., Detroit 48202
Redding, Lowell G..................1336 Southfield Rd., Lincoln Park 48146
Reder, Benjamin..17301 E. Eight Mile Rd., Detroit 48235
Redfern, W. Earl....2799 W. Grand Blvd., Detroit 48202
Reed, Ivor E. (L).............25579 Loch Lomond Dr., Dearborn 48125
Reed, Joseph O., Jr...........448 Lincoln, Detroit 48230
Reed, Melvin L...........4160 John R St., Detroit 48201
Rees, Howard C. (L)....15700 Mack Ave., Detroit 48224
Reese, James R.........Ford Motor Co., Dearborn 48127
Reichert, Carl E...18412 Mack Avenue, Grosse Pte. 48236
Reid, John G........1553 Woodward Ave., Detroit 48226
Reid, Wesley G.......3001 W. Grand Blvd., Detroit 48202
Reidt, William U............1800 Tuxedo, Detroit 48206
Reiff, Morris V.............10241 Joy Rd., Detroit 48204
Reinhard, Richard E.............7815 E. Jefferson Ave., Detroit 48214
Reinsh, Ernest R...600 Trailwood Path, Birmingham 48010
Reisig, Robert O.............20867 Mack, Detroit 48236
Reisman, Nathan J...........15344 W. McNichols Road, Detroit 48235
Reisman, Saml. G.....1553 Woodward Ave., Detroit 48226
Reive, David L. E. (A)...25447 Plymouth, Detroit 48239
Remski, James E........29447 Ravine Dr., Livonia 48152
Reno, George L..........970 Fisher Bldg., Detroit 48202
Rentenbach, Robt. F.........314 David Whitney Bldg., Detroit 48226
Resto, Manuel.........21955 Wildwood, Dearborn 48128
Resto Soto, A. D........17644 W. Warren, Detroit 48228
Reveno, Wm. S. (L)..3001 W. Grand Blvd., Detroit 48202
Reyner, Clarence E. (L)..10 Peterboro St., Detroit 48201
Reynolds, Robt. M.......856 Fisher Bldg., Detroit 48202
Rezanka, Harold J....1553 Woodward Ave., Detroit 48226
Rhoades, Francis P.............2414 16 Broderick Twr., Detroit 48226

Rice, Harold B...........10 Peterboro St., Detroit 48201
Rice, Meshel...............533 Coats Rd., Oxford 48051
Rice, William J....550 Eastland Prof. Bldg., Detroit 48236
Rick, Paul J..................12673 Joan, Detroit 48205
Riddell, Wilfred A...15420 Farmington Rd., Livonia 48154
Rieckhoff, Geo. G. (L)..........14905 E. Jefferson Ave., Detroit 48215
Rieden, James A..........18053 Muirland, Detroit 48221
Rieger, John B. (L).........746 Pallister, Detroit 48202
Rieger, Mary H. (L)...............19285 Lucerne Dr., Highland Park 48203
Riethmiller, Robt. F...........12444 E. Seven Mile Rd., Detroit 48203
Rinaldo, Joseph, Jr.........6071 Outer Dr., Detroit 48235
Rinkel, Robert W.......7319 Park Ave., Allen Park 48101
Ritter, George....28245 Southfield, Lathrup Village 48075
Rivera, Emiliano, Jr..........1800 Tuxedo, Detroit 48206
Rizzo, Paul...260 Eastland Prof. Bldg., Grosse Pte. 48236
Robb, Edward L. (L)...........17380 Livernois Ave., Detroit 48221
Robb, Herbert J.......2706 Comfort, Birmingham 48010
Roberts, Arthur J. (R).................859 Winchester, Lincoln Park 48146
Roberts, George A.......7220 Gratiot Ave., Detroit 48213
Robinson, Harold A...........16240 W. 12 Mile Road, Southfield 48075
Robinson, Howard........953 Fisher Bldg., Detroit 48202
Robinson, James H., Jr............1553 W. Grand Blvd., Detroit 48208
Robinson, Remus G.........3751 31st St., Detroit 48210
Rodin, Ernst A..........951 E. Lafayette, Detroit 48207
Roehl, Karl H.......1800 Grindley Park, Dearborn 48124
Rogers, Aaron Z..........20451 Mack Ave., Detroit 48236
Rogers, Geo. E. B...8425 Twelve Mile Rd., Warren 48093
Rogers, John T.......29586 Five Mile Rd., Livonia 48154
Rogers, Robert P...........14200 Puritan, Detroit 48227
Rogoff, Abraham S............17000 W. Eight Mile Rd., Southfield 48075
Rohde, Paul C. (L)...12282 E. Outer Dr., Detroit 48224
Rollocks, Hugh W........13800 Livernois, Detroit 48238
Roman, Stanley J...15020 Michigan Ave., Dearborn 48126
Romanski, Raymond..........16001 W. Nine Mile Rd., Southfield 48075
Romero, Carlos P., Jr.......3105 Carpenter, Detroit 48212
Ronayne, John J., Jr..........16345 W. McNichols Rd., Detroit 48235
Rood, Robert C.............17540 Stoepel, Detroit 48221
Root, Fayette C.....719 New Center Bldg., Detroit 48202
Rosbolt, James F.......8505 Plymouth Rd., Detroit 48204
Rosbolt, O. Paul, Jr.....8505 Plymouth Rd., Detroit 48204
Rose, Arthur................1800 Tuxedo, Detroit 48206
Rosefield, John L..........65 W. Hancock, Detroit 48201
Rosello, Luis........1400 Chrysler Expwy., Detroit 48207
Rosen, Harold M...8620 W. McNichols Rd., Detroit 48221
Rosen, Theodore S......19340 Monte Vista, Detroit 48221
Rosenbaum, Herbert......18110 Muirland, Detroit 48221
Rosenbloom, Alvin B.......17555 Parkside, Detroit 48221
Rosenthal, Albert....27855 Plymouth Rd., Livonia 48150
Rosenthal, Louis H...15401 W. McNichols, Detroit 48235
Rosenthal, Saml.............8844 Joy Rd., Detroit 48204
Rosenwach, Felix F...........19149 W. Seven Mile Rd., Detroit 48219
Rosenzweig, Norman...6767 W. Outer Dr., Detroit 48235
Rosenzweig, Saul.........2542 W. Boston, Detroit 48206
Ross, Arthur J...........18215 Greenfield, Detroit 48235
Ross, Charles V...........7740 Da Costa, Detroit 48239
Ross, Mervyn B...........9559 Greenfield, Detroit 48227
Ross, Oscar A................1800 Tuxedo, Detroit 48206
Rota, Alexander N............Sinai Hosp., Detroit 48235
Rotarius, Edward M......Parke Davis Co., Detroit 48232
Roth, Edward T. (L)..640 E. Grand Blvd., Detroit 48207
Rother, Ina A. C.......101 Chicago Blvd., Detroit 48202
Rothwell, Walter S.........2730 Chelsea, Trenton 48183
Rottenberg, Coleman M. J...13419 Fenkell, Detroit 48227
Rottenberg, E. N.............20725 W. Seven Mile Rd., Detroit 48219
Rottenberg, Leon......13419 Fenkell Ave., Detroit 48227
Roubeck, William............17000 W. Eight Mile Rd., Southfield 48075
Rowda, Michael S.....7 Cambridge, Pleasant Ridge 48069
Rowe, Jos. J., Jr..........401 N. Brady, Dearborn 48124
Roy, L. James..........1210 Kales Bldg., Detroit 48226
Royer, Richard R....18101 E. Warren Ave., Detroit 48224
Rubinoff, William..............21415 W. Eight Mile Rd., Detroit 48219
Rubio, Epimaco............26612 Karen, Warren 48091
Ruble, Paul E...1139 David Whitney Bldg., Detroit 48226
Rudner, Earl J.........7421 W. Seven Mile, Detroit 48221
Ruedemann, Albert D..............1633 David Whitney, Detroit 48226
Ruedemann, Albert D., Jr.......1633 Dav. Whitney Bldg., Detroit 48226
Rueger, Milton J...717 Dav. Whitney Bldg., Detroit 48226
Rueger, Ralph C....9149 E. Jefferson Ave., Detroit 48214
Ruel, Richard E...541 Dav. Whitney Bldg., Detroit 48226
Ruiz, Luis C...........1678 Merriann Rd., Wayne 48184
Rule, Jack A. (A)...Detroit General Hosp., Detroit 48226
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Rupe, Clarence E....2799 W. Grand Blvd., Detroit 48202
Rupprecht, Emil F...15901 Greenfield Rd., Detroit 48227
Rusciano, Emilio............Grace Hosp., Detroit 48201
Rush, Desmond K.............1429 Dav. Whitney Bldg., Detroit 48226
Ruskin, Robert L...........Sinai Hospital, Detroit 48235
Ruskin, Saml. H. (L)....1112 Kales Bldg., Detroit 48226
Russanow, Georg........400 E. Lafayette, Detroit 48226
Russell, Henry N., Jr...15101 Southfield, Allen Park 48101
Rutherford, Isobel..Detroit Memorial Hosp., Detroit 48226
Ruzumna, Richard A........17111 Indiana, Detroit 48235
Ryan, James M..........16888 Greenfield, Detroit 48235
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Sack, Anthony G.......18230 Grand River, Detroit 48223
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Saeed, Sheikh M......Henry Ford Hospital, Detroit 48202
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Sager, Edward L. (L)..13902 Gratiot Ave., Detroit 48205
St. Amour, Hector J. (L)........25515 Blossingham Dr., Dearborn Hghts. 48127
St. Louis, Rene J. (L).........10909 W. Jefferson Ave., River Rouge 48218
Sakorraphos, S. N. (L)..............66 Crestview Rd., Belmont, Ma. 02178
Sakwa, Saul..17000 W. Eight Mile Rd., Southfield 48075
Salamon, Fredk. A.......St. Johns Hospital, Detroit 48236
Salan, Lacy J..........1257 S. Main St., Plymouth 48170
Salazar, Fernando N.....2645 Grange Rd., Trenton 48183
Salchow, Paul T............8285 Hartwell, Detroit 48228
Salciccioli, Gino G...3930 E. Eight Mile Rd., Detroit 48234
Salem, Edward S.............22420 Twyckingham Way, Southfield 48075
Salhaney, Mitchell......15252 Levan Rd., Livonia 48154
Sallee, William T.....17000 W. 8 Mile, Southfield 48075
Salot, William H...220 Eastland Prof. Bldg., Detroit 48236
Saltzstein, Harry C. (L)..........20905 Greenfield 408, Southfield 48075
Salva, Donald L......3675 E. Outer Drive, Detroit 48234
Salvaggio, A. T.................426 Eastland Prof. Bld., Harper Woods 48236
Samberg, L. Carl........1210 Kales Bldg., Detroit 48226
Samovitz, Myron (A).........6960 Telegraph, Apt. 121, Birmingham 48010
Sand, Harry H...........24110 Oxford, Dearborn 48124
Sandberg, Hershel.........19207 Schaefer, Detroit 48235
Sander, Irvin W. (R)...........801 W. Long Lake Rd., Bloomfield Hills 48013
Sanderson, Alvord R. (L)...........978 Pemberton Rd., Grosse Pte. 48230
Sandler, Nathaniel............15901 W. Nine Mile Rd., Southfield 48075
Santino, Alphonse M...........208 Eastland Prof. Bldg., Detroit 48236
Santos, Delfin F........18101 Oakwood, Dearborn 48124
Sapala, M. Andrew...............21471 Cherry Hill Rd., Dearborn 48124
Saraf, Leo B...........14540 E. Warren, Detroit 48215

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Sargent, Richard C......17357 Fenkell St., Detroit 48227
Sargent, William R......17357 Fenkell St., Detroit 48227
Sarmiento, Manuel....Providence Hosp., Southfield 48075
Sarracino, John B. (A).......U.S. Army Hosp., Vicenza, A.P.O., New York, N.Y. 09221
Sauk, John J........302 W. McNichols Rd., Detroit 48203
Saunders, Gene A...10933 Farmington Rd., Livonia 48150
Sauter, Simon H. (L)..1082 E. Grand Blvd., Detroit 48207
Sawdyk, Daria H.........7012 Mich. Ave., Detroit 48210
Sazyc, Joseph S.........22101 Moross Rd., Detroit 48236
Scarney, Herman D...3011 W. Grand Blvd., Detroit 48202
Schaefer, H. C..........7815 E. Jefferson, Detroit 48214
Schaefer, Robt. L. (A)..76 W. Adams Ave., Detroit 48226
Schaefer, Robt. L., Jr. ....74 W. Adams, Detroit 48226
Schaeffer, J. N................261 Brady, Detroit 48201
Schaeffer, Martin......16186 Oxley Rd., Southfield 48075
Schakne, Norman........669 Fisher Bldg., Detroit 48202
Schane, David A..........19159 Berkeley, Detroit 48221
Schatten, Ivan C.....14622 E. Seven Mile, Detroit 48205
Scheer, Alan C.....Detroit Memorial Hosp., Detroit 48226
Schembeck, Isaac S. (L)..........1553 Woodward Ave., Detroit 48226
Scherer, Robert A.........470 Fisher Bldg., Detroit 48202
Schidlowsky, Oleg P...29594 Five Mile Rd., Livonia 48154
Schiller, Arthur E. (L)............1553 Woodward Ave., Detroit 48226
Schirack, Raymond D. (R)......24201 Aven Da Savilla, Laguna Beach, Ga. 92653
Schkloven, Norman.....20051 Warrington, Detroit 48221
Schlafer, Nathan H.......10 Witherell St., Detroit 48226
Schlesinger, Henry..13534 Woodward Ave., Detroit 48203
Schmaltz, John D.............1701 Dav. Whitney Bldg., Detroit 48226
Schmidt, George J......7106 Park Ave., Allen Park 48101
Schmidt, Harry E........667 Fisher Bldg., Detroit 48202
Schmidt, Johann........7815 E. Jefferson, Detroit 48214
Schmidt, Klaus P......871 Fisher Building, Detroit 48202
Schmidt, Werner F.......1807 Stroh Bldg., Detroit 48226
Schmier, Burton L. (A)............42659 Five Mile Rd., Plymouth 48170
Schmitt, Norman L............10127 W. McNichols Rd., Detroit 48221
Schneck, Robt. J.....1553 Woodward Ave., Detroit 48226
Schneider, Chas. L...22148 Michigan Ave., Dearborn 48124
Schneider, Curt P........655 Fisher Bldg., Detroit 48202
Schoenfield, Gilbert D...........8830 W. McNichols Rd., Detroit 48221
Scholdager, Rolf H...........1800 Tuxedo, Detroit 48206
Schooten, Sarah S. (L)...........15901 W. 9 Mile Rd., Southfield 48075
Schorer, Calvin E........951 E. Lafayette, Detroit 48207
Schreier, Leonard (M)...............4008 S. Yosemite, Denver, Co. 80237
Schroeder, Carlisle F...............26505 E. River Rd., Grosse Ile 48138
Schroeder, Gisela..22408 Park Lane, St. Clair Shores 48080
Schroeder, Heinz R..............1941 Hawthorne Blvd., Dearborn 48128
Schroeder, Karl F...7815 E. Jefferson Ave., Detroit 48215
Schuchter, S. L.............1800 Tuxedo, Detroit 48206
Schulte, Carl H. (L) 717 Redding Rd., Birmingham 48009
Schultz, Clarence H...23100 Cherry Hill, Dearborn 48124
Schultz, Donald V.....23100 Cherry Hill, Dearborn 48124
Schultz, Ernest C. (L)............1553 Woodward Ave., Detroit 48226
Schuman, Bernard M...Henry Ford Hospital, Detroit 48202
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Schwartz, Harold A............15201 W. McNichols Rd., Detroit 48235
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Sciarrino, Stanley V. (L).........16190 James Couzens, Detroit 48221
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Scott, Wm. J. (L)..................20170 Mack Ave., Grosse Pte. Woods 48236
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Sherrin, Edgar R....19021 W. McNichols, Detroit 48219
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Siller, Theodore N.........19190 Ohio St., Detroit 48221
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Sills, Richard D.....5675 Forman Dr., Birmingham 48010
Sills, William G..........19321 Greenfield, Detroit 48235
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Silver, Israel W........20000 W. Chicago, Detroit 48228
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Silverman, Max......2240 W. Grand Blvd., Detroit 48208
Silverstein, M. E...952 Dav. Whitney Bldg., Detroit 48226
Silverstein, O. D...17000 W. 8 Mile Rd., Southfield 48075
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Simpson, Gordon E...18101 E. Warren Ave., Detroit 48224
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Stein, Saul C..........23105 Van Dyke, Van Dyke
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Stocker, Marvin L.....16401 Grand River, Detroit 48227
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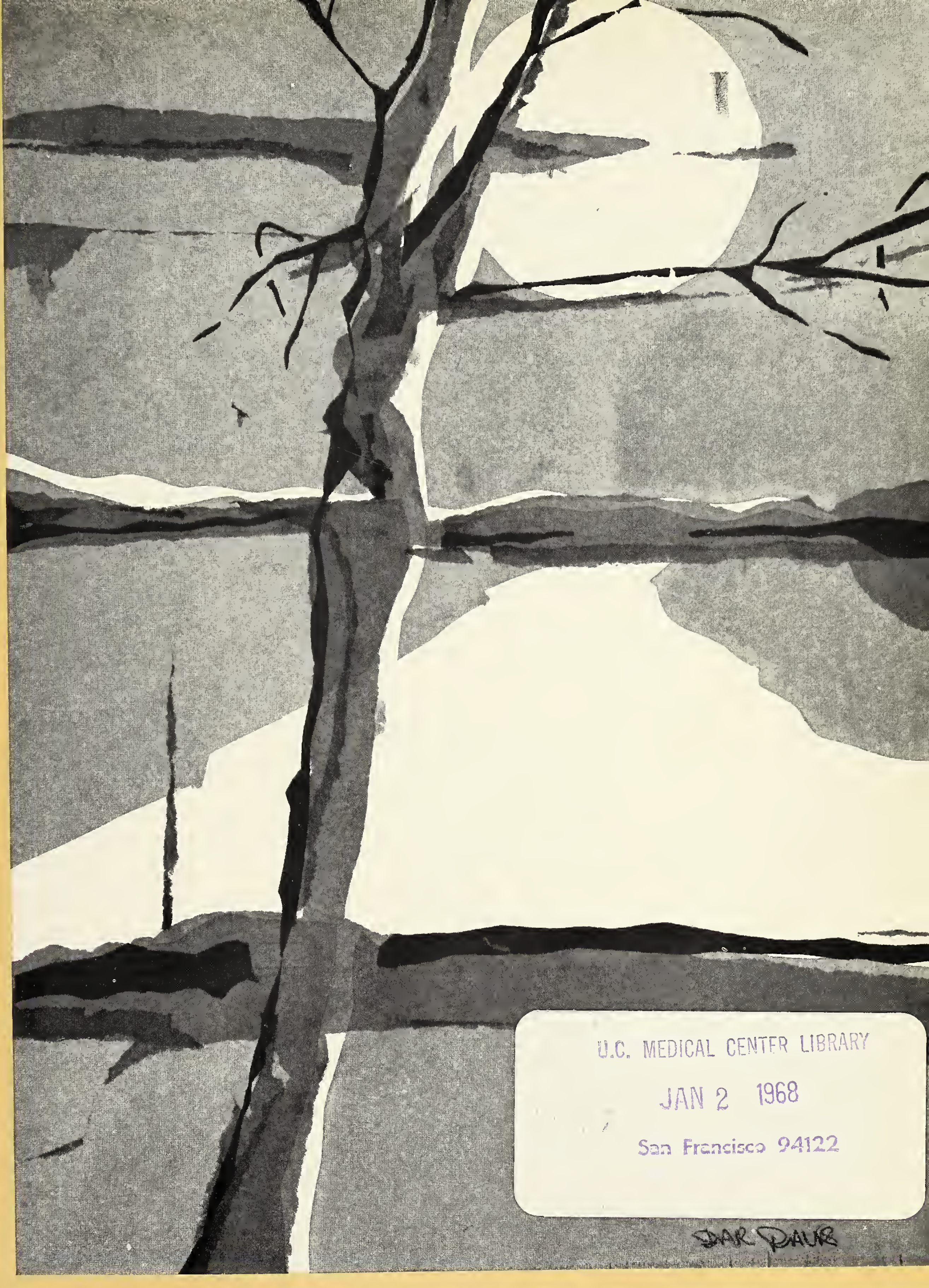

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Chemoprophylaxis: A Major Adjunct in the Prevention of Tuberculosis

What Is Current MSMS Thrust in Science, in Medicine?

Dilantin®
(diphenylhydantoin)
PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.

(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. HW&D BALTIMORE, MARYLAND 21201

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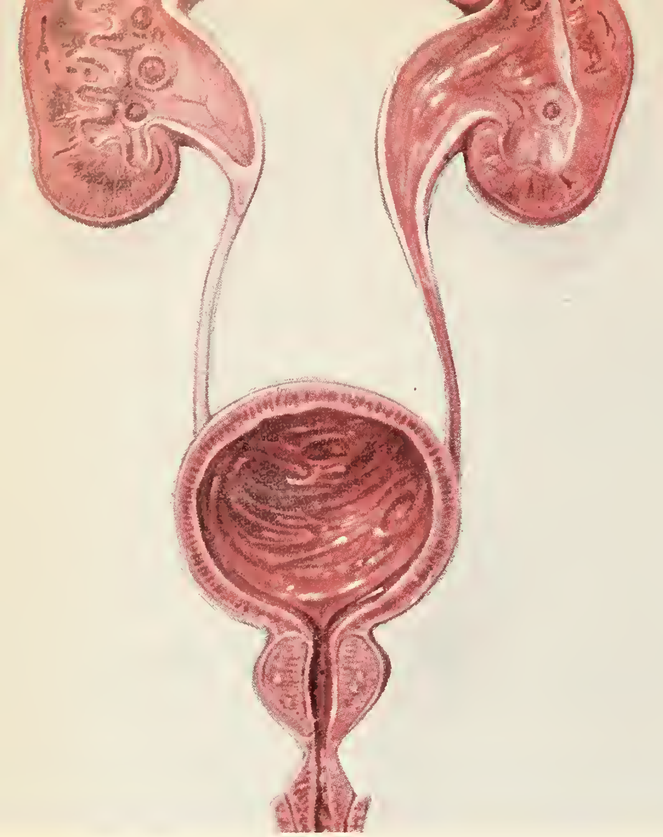

Summary of prescribing information

Indications: Urinary tract infections in which gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas*. Gram-positive bacteria are less sensitive to NegGram but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: As with all new drugs, periodic blood and liver function tests are advisable during treatment longer than 1 or 2 weeks. **This drug should be used with caution in patients with liver disease, epilepsy, severe cerebral arteriosclerosis, or severe impairment of kidney function.** Because photosensitivity reactions have been reported in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a photosensitivity reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Should bacterial resistance develop or additional nonsensitive strains emerge, other effective antibacterial agents should be added to or substituted for NegGram.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents may give a false-positive reaction.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances; less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia in patients with a deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache has been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: *Adults* — Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 Caplet of 500 mg. four times daily). *Children* — According to age and weight: approximately 25 mg. *per pound* of body weight per day, administered in divided doses.

Note: The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied:

- **For adults** — Buff-colored, scored Caplets of **500 mg.**, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000.
- **For children** — Caplets of **250 mg.**, available in bottles of 56 and 1000.

Before prescribing, please refer to complete prescribing information.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

NegGram

Brand of
nalidixic acid
a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

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Volume 66, Number 24

Cover: The cover art is symbolic of the winter season and the holidays. The silkscreen print, in shades of gray, is by Dar Davis, graduate assistant in art at Michigan State University.

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president's message

NOT BY DEFAULT . . .

Society has always been concerned with its health. As advances in health related medical knowledge develop, the opportunities to make these readily available assume greater impetus. New programs for community participation are emerging rapidly. Community leaders avidly seek doctors of medicine to participate in these civic programs.

A.M.A. President, Milford O. Rouse, at the AMA Communications Institute said "The opinion leaders reveal their strong desire to be able to utilize the knowledge, the emotional stability and the logical thought processes possessed by most physicians."

There is a feeling generally prevalent among civic leaders that doctors do not "pull their share of the load" in community activities. One often hears the complaint "that physicians take more out of their community than they contribute to it."

LET EACH OF US as members of MSMS ask himself, *"Is this true in my own life?"*

Doctor Rouse told the Institute participants that community leaders are "almost universally agreed that a very small minority of individual physicians do participate in certain pet projects in which they have some particular interest, but that the medical community as a whole, or even as a majority of the profession, does not participate in affairs that affect the entire community unless there is some direct relationship to health."

No community program as it evolves can escape implications related to the mental and/or physical well-being of its citizens. At this point the background and training of the medical community becomes indispensable. The logical resolution of these programs is our community responsibility. We must do more than pay our dues to community groups. We must take part in meetings and make ourselves available for positions of responsibility.

Again to quote Doctor Rouse:

"As we find ourselves understanding more and more about the overall problems of our community we will become available to the person who seeks participation. As a leader, we have a chance not only to absorb knowledge about what other segments of our community want and need—but also an unparalleled opportunity to make our fellow citizens aware of the things that our profession wants and needs —and the things our profession has accomplished—as well as the problems it faces."

Let us each take a look at the programs and projects of our chambers of commerce, service clubs, church groups, PTA's, etc.

I KNOW WE will readily recognize that most of these have broad ramifications related to medical and health subjects, i.e. zoning, pollution, recreation, better schools, family life education, to mention a few.

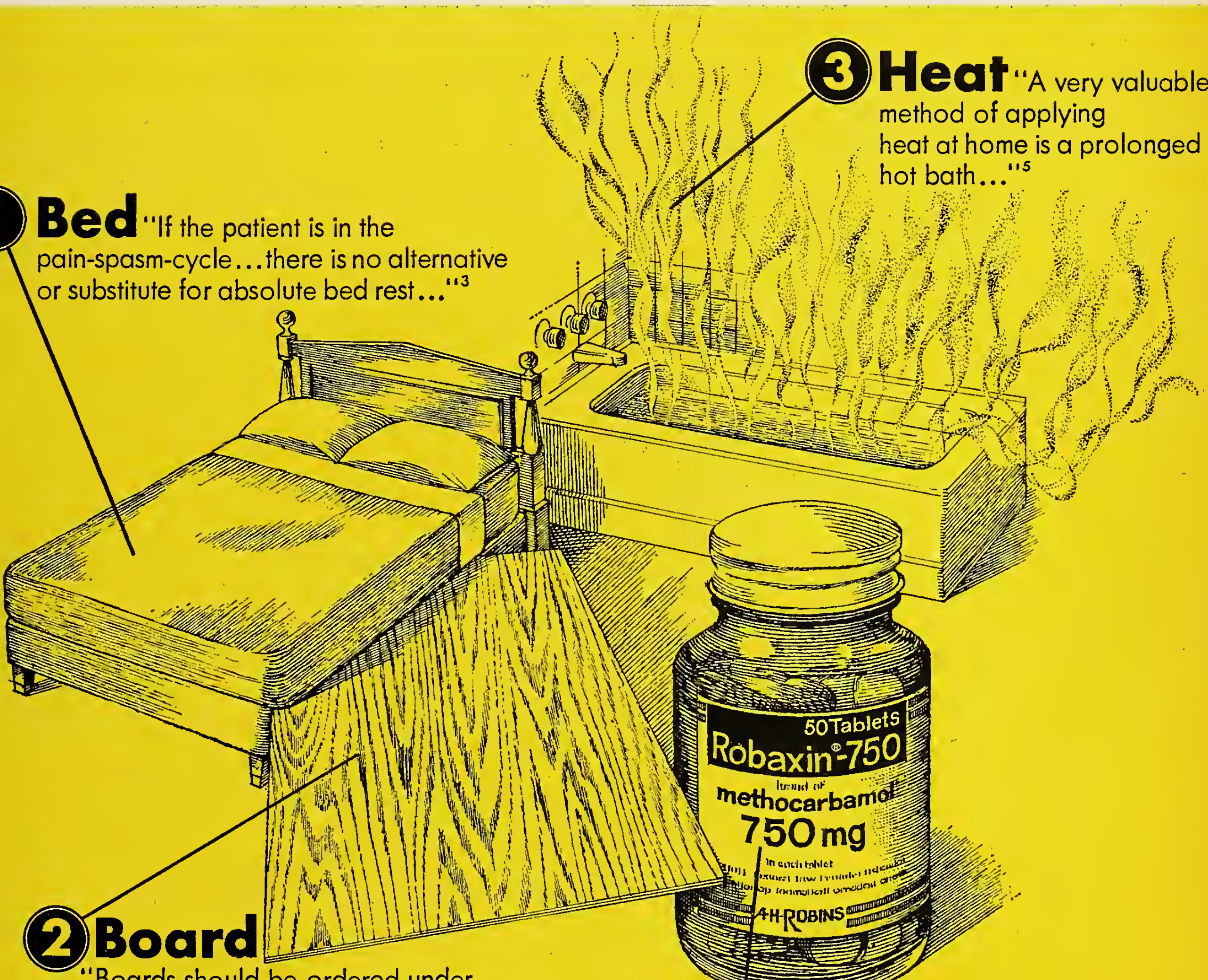
We have so many opportunities to serve our communities and bring our professional backgrounds to the resolution of social needs. Let us not by default allow these organizations to proceed without our involvement.

B. M. HARRIS, M.D.

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



① Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

② Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

③ Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

④ Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

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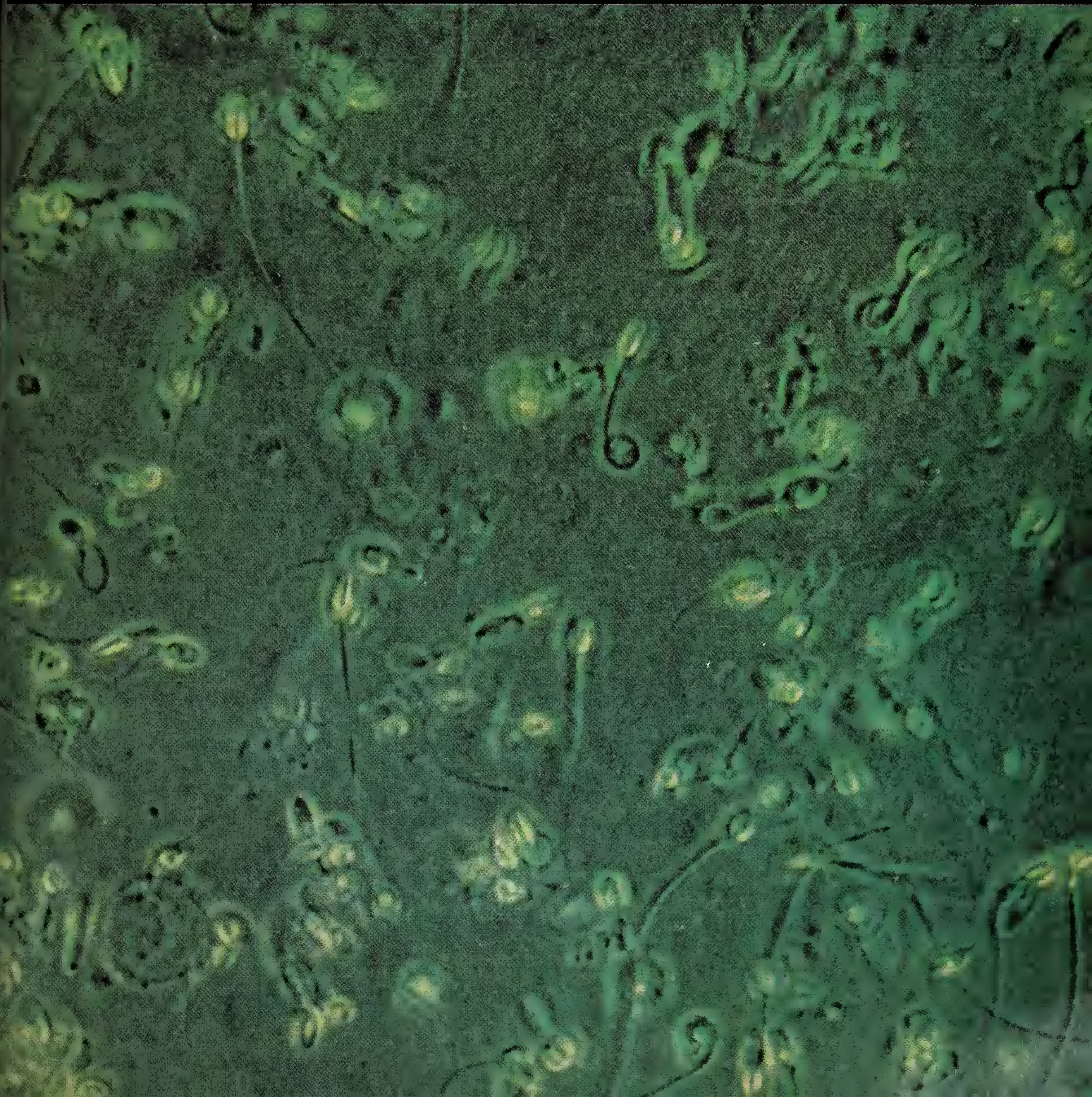
Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

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In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidenc in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast change (tenderness, enlargement and secretion), change in weight (increas or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

---

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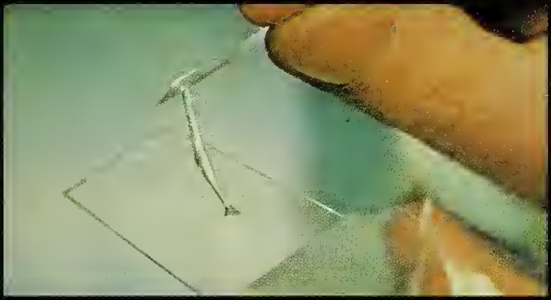
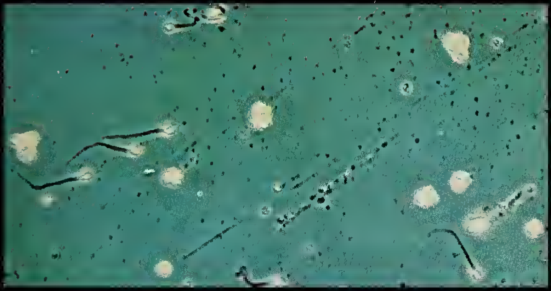
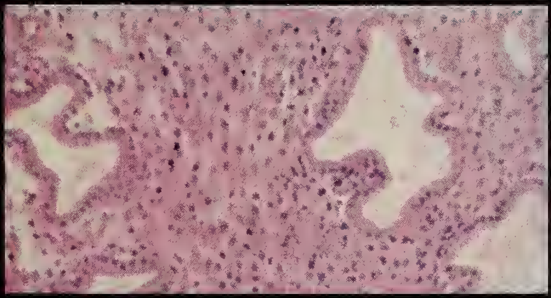
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

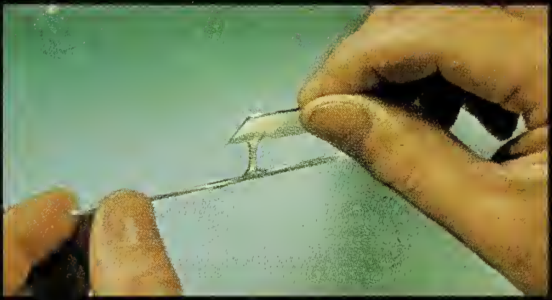


Spermatozoa appear healthy, active, freemoving.

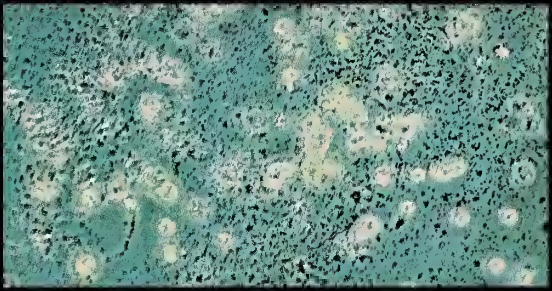


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

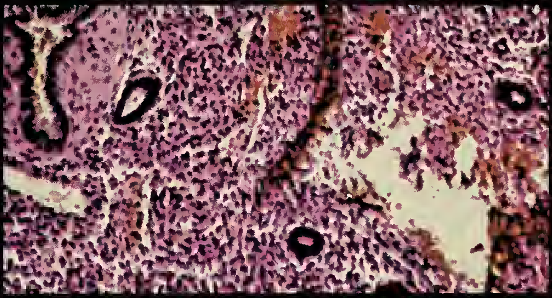
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



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Synalar®
fluocinolone acetonide

Turn page for contraindications, precautions and side effects

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Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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Abstract — Isoniazid chemoprophylaxis of priority groups among all persons infected with tubercle bacilli can substantially reduce the number of cases of active tuberculosis in Michigan during the next 15 years.

Chemoprophylaxis: A Major Adjunct In the Prevention of Tuberculosis

BY EZRA V. BRIDGE, M.D.
PORT HURON

Chemoprophylaxis with isoniazid of all persons fected with tuberculosis would reduce the num- r of new active cases by at least 65 per cent. A ash program to identify all such persons im- ediately and to treat them is impractical, for ere are now an estimated 1,100,000 persons in- cted with tubercle bacilli in Michigan. The timate includes all cases of clinical tuberculosis, tive or inactive, and all positive tuberculin actors who have no other evidence of infection ith tubercle bacilli. Only about 190,000 of the 100,000 are identified today.

To approach the problem realistically, a 15-year mpaign is being organized in Michigan to find l persons infected and to treat those in priority oups with isoniazid. The objective is to reduce e incidence of active tuberculosis by at least ne-half so that new cases of tuberculosis in 1982 ill total 870 or less instead of the projected 750 that would occur without a comprehensive rogram of chemoprophylaxis.

All of us who practice medicine or surgery, hether generalist or specialist, in private practice, ademic or institutional medicine, are urged to ke part to assure the success of the program.

Effect of Chemoprophylaxis

At the outset we must accept the fact that hemoprophylaxis of tuberculosis with isoniazid effective, although it may be something less an one hundred per cent. In support of this re the results of the cooperative study of the rophylactic use of isoniazid among household ntacts published by Ferebee and Mount in 962[1]. Thirty-nine health departments took part in the study. These were scattered among 16 states (6 in Michigan), Puerto Rico and Mexico. Shortly after identifying the index case of tuberculosis in each of 6,219 households, a total of 25,512 household contacts were examined. This turned up 479 cases of active tuberculosis immediately and left 25,033 contacts for random assignment to one year's treatment, half with isoniazid and half with placebo. The preventive effect of treatment is illustrated by comparing the number of cases of tuberculosis appearing in isoniazid-treated contacts with placebo-treated contacts:

	Treated with isoniazid	Treated with placebo
Cases of tuberculosis developing in children	9	32
Cases of tuberculosis developing in adults	14	62
Total	23	94

In other words, the isoniazid-treated contacts ran only a quarter of the risk of developing tuberculosis during treatment as the placebo-treated contacts.

Priority Groups

All persons infected with tubercle bacilli (manifested by a positive tuberculin reaction) run some risk of developing active tuberculosis. For most the risk is too small to justify a year's treatment with an antituberculosis drug. For some the risk is considerably greater. For example, there is a definite increase in the risk if the tuberculin reaction is large, especially in persons under 25 years of age. If 5 tuberculin units generate a tuberculin reaction measuring 20 mm or more in diameter in 48 to 72 hours, the tuberculin reaction is considered large. An intradermal dose of 0.1 cc of the diluted Old Tuberculin distributed by the Michigan Department of Public Health is equivalent to approximately 5 tuberculin units of

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Doctor Bridge, who specializes in internal medi- ine, is chairman of the Research and Medical ducation Committee of the Michigan Tubercu- osis and Respiratory Disease Association, and a ember of the association board of trustees.

PPD-S (Purified Protein Derivative-Standard) or approximately 0.0001 mg of PPD-S.

To be applied sensibly and practically, chemoprophylaxis should be given persons falling in certain *priority groups* outlined in 1961 and again in 1965 by the Committee on Therapy of the American Thoracic Society[2, 3]. The groups are as follows:

1. Persons of any age who are household contacts of a case of active tuberculosis. A growing number favor the idea of treating all household contacts whether tuberculin-positive or tuberculin-negative. Contacts of active tuberculosis whose tuberculin reactions turn from negative to positive run a greater risk of developing tuberculosis than do converters without known exposure. Therefore it seems sensible to treat the household contact before his tuberculin reaction becomes positive.

2. Adolescents whose tuberculin reactions have changed from negative to positive within the previous one to two years.

3. Tuberculin-positive children under the age of 3 years.

4. Persons in other age groups whose tuberculin reactions have converted within the previous one or two years, particularly if the tuberculin reactions are large (20 mm or more in diameter) or if exposure to an infectious case of tuberculosis is known.

5. Persons with silicosis and positive tuberculin reactions.

6. Persons with positive tuberculin reactions who are receiving prolonged treatment with corticosteroid drugs, or who have severe or unstable diabetes mellitus, or who have had or who are about to have gastric resection. The indication for chemoprophylaxis is greater if the tuberculin reaction is large or if there is roentgenographic evidence of healed tuberculosis.

7. Pregnant women with inactive tuberculosis. Treatment is begun in the last trimester and pursued for at least six months after delivery.

8. Tuberculin-positive children with measles (acquired or induced by vaccination) and pertussis. Treatment is initiated during the attack and carried on for 2 or 3 months after the attack

9. Tuberculin-positive persons with undi nosed pulmonary lesions providing other etiolog (neoplasms in particular) have been excluded

There are four more groups to think abo The risk of breakdown varies from one to t next and the need for treatment varies accordi ly. The groups are as follows:

1. **Nearly imperceptible progression of pulmon tuberculosis.** In these the pulmonary lesions sh no change when one annual film is compared w the next, but when a series of films are compar slight increase in the size of one or more ar becomes apparent. Adequate treatment with m than one drug is mandatory because the dise is active, though only smoldering.

2. **Inadequate treatment of tuberculosis in multi sites.** Persons with a long history of inadequa treatment of tuberculosis in two or more si (lung, kidney, bone, etc.) run a high risk breakdown. Correct treatment for them is impe tive.

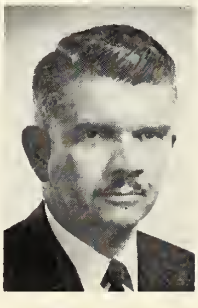
3. **Inadequate treatment by current standards.** P sons whose tuberculosis was inactivated by tre ment before the widespread use of antituberculo drugs (or those who were treated insufficien with drugs by present-day standards) have a gre er risk of reactivation than those given sufficie treatment by current criteria. Proper treatme may be in order.

4. **Scars but no history of active disease.** Pers with less risk of breakdown are those with history of active disease but who have roentge graphic evidence of inactive re-infection tuber losis. If their tuberculin reactions are positive a their inactive lesions appear to have no ot cause (e.g., histoplasmosis), they may have l but still an appreciable risk of breakdown. Tre ment for some of them may be in order.

Relentless chemotherapy of every active c of tuberculosis for the optimum length of ti plus other measures when indicated are the b preventive for the four types of problems j listed.

AUTHOR

DOCTOR
BRIDGE



Regimens Recommended

Isoniazid is the drug recommended for chen prophylaxis. One prescribes 300 mg per day adults and 10 mg per Kg of body weight children, the latter not to exceed 300 mg nor less than 75 mg per day. Traditionally the amou of isoniazid to be given each day has been divid into three doses. Since the patient must take medicine for months or years, his enthusiasm long-term treatment may flag. Giving the da quirement in a single dose helps insure against egular, interrupted or abandoned treatment.

Hyde[4] has shown that a single daily dose of 0 mg of isoniazid is as effective as 100 mg three nes daily in the treatment of minimal and ncavitary moderately advanced pulmonary tu- rculosis.

When the clinical problem demands the con- rrent use of a second oral drug, para-amino- licylic acid (PAS) may also be given in a single ily dose. Wilson and Lampe[5] reported no thera- utic advantage when they compared single and ultiple daily doses of isoniazid and PAS. They tted a single daily dose of 300 mg of isoniazid us a single daily dose of 12 Gm of PAS (24 lf-Gram tablets) against a regimen of 100 mg isoniazid plus 4 Gm of PAS (8 half-Gram blets) three times daily.

One may reduce the number of tablets of PAS eded per day by prescribing a purified form of AS recrystallized in the presence of ascorbic acid nd marketed as PAS-C (Pascorbic®) by Hellwig, nc., of Chicago. For adults, one prescribes 6 to 8 ms of PAS-C (12 to 16 half-Gram tablets) per y which gives blood levels of PAS equal to those tained with 12 Gms of PAS (24 half-Gram blets) when measured six hours after administra- on. One calculates the dose for children at 150 g of PAS-C per Kg of body weight. If the child nnot handle the number of tablets of PAS-C ecessary for a single dose, the amount can be ivided and given in two doses.

IN BOTH CHILDREN AND ADULTS, treat- ent is pursued for at least a year, sometimes two r three years, and in some cases for the balance f the patients' lives.

Toxic reactions to isoniazid are rare, peripheral euritis being the most common. They are re- ersible by interrupting treatment and giving yridoxine 50 to 100 mg per day. Pyridoxine is lso used to prevent peripheral neuritis when a elatively high dose of isoniazid increases the ikelihood of neurotoxic reaction. Intolerance to AS is frequent, gastro-intestinal complaints being he most common. They disappear when PAS is topped. Since another form of PAS may be better olerated, a change in the form of PAS is worth rying (e.g., the calcium salt of PAS or resin- ound PAS). There are no reports of delayed eactions appearing long after cessation of treat- ent with isoniazid or PAS.

The problem of treating the recalcitrant tuberc- lous patient with drugs for a sufficiently long ime is a difficult one. It will always be with us. barbaro and Johnson[6] reported no relapse among 5 unreliable patients followed and treated for 16 onths after hospitalization. They gave their pa- ents high doses of isoniazid and streptomycin, each drug being given twice a week through an outpatient facility. A similar scheme might work among Michigan's recalcitrants.

Periodic Examinations

One must bear in mind that active tuberculosis may appear in some persons during or after and in spite of chemoprophylaxis. Therefore, periodic examination is necessary for all persons receiving chemoprophylaxis. They should have X-ray examinations of the chest and tuberculin tests (if they previously failed to react to tuberculin) at three-month intervals during the first year of treatment, and at six-month intervals if treatment continues beyond one year. Once treatment is completed, the frequency of examinations and the duration of followup will vary with the requisites of each case.

Conclusion

We can reduce the incidence of tuberculosis in Michigan substantially during the next 15 years. The materials for the conduct of this campaign are simple . . . tuberculin, X-ray film and isoniazid. The facilities and personnel exist . . . our offices (yours and mine), our nurses, our colleagues in academic medicine, institutional practice and public health. Unstinting use of the tuberculin test and X-ray examination of the chest will identify virtually all persons infected with tubercle bacilli. A little thought will assign them to priority groups for chemoprophylaxis. Explanation and encouragement will keep each patient taking his medicine for the year or more if he needs it. And 1982 will see the tuberculosis problem in Michigan dimidiated.

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SCIENTIFIC ARTICLE

Abstract — Most children learn to read with the same facility as their agemates. Some other children cannot learn to read so readily. Their attention, comprehension, perception and memory of the abstract symbols of letters, words and sentences are poorly developed. These children have a neurologic dysfunction called dyslexia. They present a great challenge to physicians and educators.

Dyslexia: A Neurologic Dysfunction

BY CHARLES W. SELLERS, M.D.
DETROIT
DONALD A. SELLERS, B.S., B.A., M.A.
GARDEN CITY

We "look" with the eye, but we "see" with the brain.

In this case "see" means to comprehend, to interpret, and to perceive as a highly complex function of the brain. The impression received by the retina is transmitted along the optic nerve as an electric impulse to the cortex. A visual image relayed to the brain is subject to interpretation and to consciousness of meaning or perception. The ability to interpret visual and auditory sensations must be acquired, learned. The process of learning to perceive takes place in childhood and is not always retained in memory. Memory is selective because the attention is selective at the time of seeing.

Persons who have become blind give definite evidence of having trouble in orientation, and they accomplish it by means of tactile and auditory aids or a kinesthetic sense rather than by memory. Persons who have been blind from birth and then gain sight, always face a slow and tedious phas of learning to see. At first they cannot understan things they look at and must coordinate touchin and hearing with vision. Slowly vision becom dominant over touch.

DYSLEXIA IS AN IMPAIRMENT of the con munication between the eye and the brain, b tween vision and perception, between the primar image and memory, between looking and seeing.

Learning to read is very essential for life in world dominated by signs and symbols, writin and reading. The ability to read capably is a pre requisite for much learning, communication, an pleasure. The person who does not read well i isolated from participation in the world of th printed page.

A great many school children encounter seriou difficulty in learning to read. Estimates vary, bu probably 20 to 25 percent of all school childre suffer from some degree of reading difficulty and generally it is severe enough to interfere wit progress in learning. Such school children ofte seem to be immature, inattentive, uncooperative and quite disturbing in the classroom because o their overactivity.

They are handicapped in school subjects re quiring reading, writing, and spelling, but ma

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lo better in simple mathematics and mechanics. Obviously they encounter hardship, despair, frustration, and failure.

Many of these children are of normal or superior intelligence, but they seem unable to pay attention for any length of time and resist efforts of teachers. Their concentration and perception of alphabetic symbols, words, and sentences are under-developed or impaired. Memory of pronunciation and meaning of letters and words are equally vague or transitory.

MEDICAL KNOWLEDGE of dyslexia dates back at least a hundred years when the term "word blindness" referred to persons with normal sight but with impaired perception of letters and words and an inability to learn to read.

The majority of children with reading difficulty are not stupid or mentally retarded, although they may seem to be. They have been accused of not trying. Most of them try very hard. Often they are not recognized early, and proper evaluation and management is delayed. Other children in the school can be very cruel and may torment them about their backwardness the result of which is some anxiety, retirement, and depression.

Dyslectic children may have mirror images of letters and words and an inability to grasp the whole word. When trying to read, some small words are omitted and word order may be reversed. Numerals may also be reversed. Quite frequently no clear indication of right or left handedness is made, hence a high incidence of ambidexterity occurs indicating the possibility of incomplete development of cerebral hemispheric dominance.

As a result of an imperfect directional sense, the dyslectic child is likely to look at "b" and see "d"; "p" becomes "q"; "was" may be called "saw," and "on" may be written "no." Numbers may be similarly reversed with "25" becoming "52." Vertical confusion may result in "M" becoming "W," and "d" may be "p."

MANY TIMES THE student has trouble recognizing the same letters and words when they are in another sentence, context, size, or color. A simple word like "daddy" may present difficulty because it can be written in all capitals, all small letters, all italics, the first letter capital "D" and two other "d's" in small letters, or all printed or all longhand script.

A child with dyslexia can learn one form of a letter or word, but it might seem totally strange in another form. He is constantly confronted by shifting, unreliable, abstract symbols that deceive him by the different appearances of the same letter or word.

An error of perception of visual and auditory symbols prevents their proper recognition and comprehension. Some writers have included within the meaning of dyslexia, developmental lag, inability to pay attention for any length of time, minimal changes in brain function and neurologic disorders. Some cases improve with specific training, but others are less encouraging. Dyslexia is four times more prevalent in boys than in girls.

The Johns Hopkins Conference on Dyslexia defined the disability as a genetic, neurologic dysfunction, uncomplicated by other factors. Awareness of the condition has not penetrated to all physicians nor to a great many educators including classroom teachers who really are most in need of it.

CO-AUTHORS

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Etiologic Factors

Most dyslectic children are emotionally unstable, disturbed, and immature. A few have been ill or debilitated. Some have experienced changes of teachers, schools, or teaching methods. Domestic discord, lack of supervision, anxiety, feelings of inadequacy about learning to read, and development of non-cooperation or overt rebellion against educators are factors.

Some investigators have thought that teaching the Gestalt whole-word reading plan instead of the phonic system handicapped poor readers. Others have written that the use of the phonic system will not forestall or ameliorate dyslexia in any appreciable number of cases. Clearly, some as yet untested techniques are needed.

The best efforts of educators are frustrated when some students take but slight interest in study and learning. Ideas of resistance to education are contagious. Concentration and study are hard work, and hard work is not popular. In some areas an attitude of superficialism pervades the land.

The more serious cases of dyslexia may be the result of mental deficiencies, birth injuries, neurologic dysfunction associated with hypoxia at birth, hyperkinetic states, word blindness, and a possible lesion in the occipital pariental region of the brain.

A prime area for investigation of the cause of serious dyslexia may be the interval from delivery of an infant to its first breath. Oxygen is critical to newborn babies, particularly premature ones. Too little may lead to dyslexia, and too much may cause retrolental fibroplasia.

Remedial Efforts

The initial appraisal should include accurate evaluation of vision, hearing, general intelligence, perceptual ability, and reading impairment. An attempt should be made to determine if reading disability is a developmental delay or a more organic neurologic dysfunction.

Children with reading disability should be sent to special reading classes and then to special reading schools. Dyslexia is a continuing disability and requires educational training by the most sophisticated techniques. Several years of intensive daily training designed for individual treatment with one student and one teacher for short periods is suggested. Repeated association of visual symbols with sound and touch in a word-sound-meaning sequence is thought to help. Cut-out or magnetic letters to be placed on a metal background might help.

Hyperkinetic or overactive children should be handled less than other children. They should not be exposed to excessive stimulation in early life. Dyslectic children will perform better in an isolated environment, free from distractions, loud noises, loud colors, confusion, and television.

The neurologic dysfunction in dyslexia is one of altered perception. Obviously, the children face real difficulties in trying to comprehend and to remember the use of written symbols as names of familiar objects. At first they find little relationship between the three letters of C,A,T, and the animal.

Some anxious parents are disturbed by such labels as organic brain damage. Perhaps physicians should avoid the use of "organic" and "damage" and concentrate on function.

TEACHING DYSLECTIC children has some barriers, but they are not insurmountable. The first requirement is a teacher with a basic knowledge of the problem and the training needed combined with the patience and ingenuity to devise special techniques for a particular child. The second requirement is parents who are willing to study the problem and to learn with the child. Third is diagnosis while in the primary grades.

These assets and one or two years of intensive study, depending on the severity of the condition, will prepare some of the children for re-entry into regular school classrooms. Even with these advantages, however, the children will need understanding and assistance from their family and teachers.

Drug treatment is limited. Overactive children have been helped by antidepressants. This seems contrary to expectations, but we must accept the pragmatic results. Amphetamine came into use, but its anorectic effect in children impaired nutrition. Ritalin® is helpful (without depressing the appetite) and is widely used. More recently, Aventyl® has been used with encouraging results. Dosage is 10 or 25 mg, one, two, or three times daily, according to effect. Vasodilators and anticonvulsants are ineffective.

The more we read about any particular illness, and the more we discuss the condition, the better able we will be "to cure sometimes, to relieve often, and to comfort always."

Summary

A serious reading difficulty of school children called dyslexia has been described. Its incidence, implications, symptoms, causes, and treatment as known have been presented. It is assumed to be based on a neurologic dysfunction. As more people know about dyslexia, more thought will be directed to it, and progress will be made.

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EDITORIAL COMMENT: The following brief communication from Doctors Brandt, Jones, and Mather seems very pertinent to include in the section for scientific articles of MICHIGAN MEDICINE. Such an outline presented to the patient who has recently experienced a myocardial infarction could prove most helpful. It could also save a good deal of time in going over details with each patient individually. The precise format and wording could obviously be changed to suit the individual using such material.—George Lowrey, M.D., Scientific Editor.

Instructions for the Patient Following Myocardial Infarction

BY RALPH L. BRANDT, M.D.
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ALL OF ANN ARBOR

You have been in the hospital under treatment for a *heart attack* which may also be termed a *coronary thrombosis* or *myocardial infarction*. This is caused by the blocking of one of the small vessels of the heart by a blood clot which we term a coronary thrombosis, resulting in an area of heart muscle injury which we call a myocardial infarction. Like any injury, for example a scar from an appendix operation, this heals with time and the scar tissue becomes even stronger than it was prior to the heart attack.

Following a heart attack and on many occasions prior to the heart attack, discomfort or distress is noted in the chest, neck, or arms which is called *angina pectoris*. This is due to a spasm of one of the tiny coronary vessels. Any discomfort in the breast bone or front part of the chest with or without radiation into the neck or arms or even aching in the arms themselves, especially on the left, may be a warning since spasm of one of the small vessels of the heart may be occurring. Angina may be precipitated by exertion but may also be associated with excitement or eating. If angina occurs, we advise cessation of activity and the use of nitroglycerin as described below.

Angina is sometimes confusing to the patient since the discomfort is usually an aching or pressure sensation rather than sharp pains and it is actually quite unusual for angina to consist of true sharp pain. Unusually rapid beating of the heart or irregular heart action, often referred to as palpitations, may indicate increased work of the heart and should lead to decreased activity.

TO ALLOW COMPLETE healing of the area of injury and to prevent further attacks, the following are suggested:

1. Avoid sudden exertion or prolonged exertion which might lead to undue fatigue.
2. Avoid emotional tension which might arise from fear, anger, etc.
3. Avoid temperature extremes, whether they be too hot or too cold.
4. Limit your activity as you have in the hospital, while generally increasing it a little each day as follows:
    a) For the first week at home, walk only in the house and to the front porch and durthe following week you may take very short walks in the yard.
    b) During the third and fourth weeks you can increase your walking and may go for rides in the car but we would prefer that you not drive and avoid stair climbing if possible.
    c) During the fifth through eighth weeks we would envision you gradually returning to your normal activities but would never anticipate your carrying out heavy exertion such as shoveling snow, mowing grass (especially with a hand mower), carrying heavy packages, etc.
    d) We usually advise refraining from returning to work for at least two months after arriving home, but this is an individual

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matter. If possible, go only part-time for the first few weeks.

e) Any of these instructions regarding activity may need to be altered depending upon the individual case under consideration.

5. Rest for one-half to one hour after each meal and spend at least ten hours in bed each night, preferably in a single bed for one or two months. Elevation of the head of the bed may be more comfortable.
6. Do not cross your legs when sitting.
7. DO NOT SMOKE
8. Maintain your weight near the figure advised by your physician and follow the diet as outlined by the dietician. Your diet should avoid animal fats and you should not eat large amounts of any type of fat at one time or ingest excessive quantities of food. In general, it is wise to omit excess salt and leisurely eating is desired.
9. An occasional alcoholic beverage is allowed.
10. Remember that certain pleasant things can be stressful. Do not let your friends or family tire you or political speeches or a ball game upset you.
11. It is wise to avoid stimulants such as coffee or tea.
12. Your physician will discuss certain events such as sexual activities, which generally should be avoided for two months after returning home.
13. It is desirable to practice deep breathing several times a day.
14. Move your arms through a full range of motion several times a day to prevent any arthritic symptoms in your shoulders.

AMONG YOUR MEDICATIONS, all of which ear the name and instructions on the label, are everal needing special instructions:

1. *Anticoagulant—"blood thinner."* One bears the instruction "take as directed as a blood thinner." This medicine is used to thin the blood and periodic blood tests will be required to adjust the dosage since too little of the medicine will do no good and too much may cause bleeding. The tests requested are termed prothrombin tests and usually are obtained every one to two weeks after your discharge and then are obtained less frequently after you have been home a while, the frequency depending on the individual case. This test can be obtained at most laboratories in your vicinity and the results will be reported to your doctor who will then instruct you regarding any change in the dose of the drug. It is important that you report any bleeding promptly to your doctor. This includes nose bleeds, blood in the urine or stool, and easy bruising or excessive bleeding as from a razor cut. Never take any Aspirin or Aspirin-containing products since these may increase the tendency to bleed. It is also wise to be very moderate in drinking alcoholic beverages since this also may increase the chances of bleeding. (Medications for the common cold, headache, allergies and rheumatism may contain Aspirin).
2. A second medicine is labelled *Nitrogylcerin.* It is dissolved under the tongue as directed for chest discomfort. Keep nitroglycerin with you at all times and use it immediately for any chest distress. If one tablet gives you no relief, the second and still a third may be repeated three to five minutes apart. (There is little danger in this dosage schedule, although a headache may appear). If a maximum of three tables does not relieve your discomfort and you have other medicines given by your doctor for pain, take it. Of course, you should immediately stop what you are doing and assume a comfortable position. If your discomfort persists despite these medications, call your physician or have your family take you to the Emergency Room of the nearest hospital. Nitroglycerin may also be used in a prophylactic manner, that is, one may place a tablet under the tongue prior to undertaking any activity which is known to produce chest distress. This will be discussed with you by your physician. Nitroglycerin tends to lose its effectiveness so that we advice you have your prescription refilled at least every six months. It tends to deteriorate faster when exposed to sunlight and it is preferable to keep it in a plastic or glass container since metal increases its deterioration.
3. Other medications will be advised according to the individual case and the names will be added at the end of these instructions.

List of Medications:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Finally, congratulations on your recovery so far and much of your continued recovery will be up to you so be a patient patient.

Michigan's Family Life Education Program Explained at National AMA Conference

(Editor's Note: Edwin C. Galsterer, M.D., of Saginaw, presented a speech at the 11th National Conference on Physicians and Schools. The talk outlined the ambitious MSMS program in the field of Family Life Education. The speech, with a few deletions, is reprinted here.)

That a program of Family Life Education in our schools is necessary and desirable is no longer the question.

We have been bombarded with critical analyses of our social problems and are weighted down with reasons why our young people need a different kind of education to help them to face the future. We are aware now that neither parent, church or school, nor even all three together, has been doing an adequate and complete job. And those of us who are doctors have realized for some time that while "educators must educate," the medical profession has something special to offer in this field. What form should this program take and how can it be implemented?

IN MICHIGAN, WE have had several outstanding instances, progressive within the limits of available talent and existing Michigan law. The Flint public school system, under the direction of George Chamis, Ph. D., has instituted one of the best programs in the state. This is an unusual case, however, because of the special facilities afforded by the Mott Foundation in Flint to finance the program and provide backing for specialized training of teachers. Lansing has also been known for its progressive program. There, too, however particular facilities have been made available through the State Department of Education.

In Kalamazoo, one school district has pioneered in the organization of such a program, while extensive work has been done under the combined efforts of the Council of Churches, the Social Welfare Department, the Board of Education and the Child Welfare Committee of the Michigan State Medical Society.

UNDER THESE AUSPICES and through the special talents and hard work of Dr. and Mrs Frederick J. Margolis, and co-sponsored by Wayne State University, an excellent movie has been produced called "Parent to Child about Sex." This movie has been used extensively for presentation of our program to civic and cultural groups throughout the state and is also available for use in the schools.

In other communities, we are still struggling with what we consider our Short Range Program, which involves stirring up interest and support in the community. In carrying this out, our Committee has long recognized the need for more than "sex education." We realize that young people can be very well informed on the biological facts of sex and still not be prepared to fulfill their potential as men and women in the social community. Dr. Mary Calderone's emphasis on sexuality as opposed to sex (or rather, not opposed, but as an extension of sex to include all of the abilities, talents and potential satisfaction possible to a person *because* of his sex) has become the definitive factor in the Family Life Education program.

Now—how is this *Short Range Program* being carried out?

Locally

Our interested doctors are giving talks to PTA groups, women's clubs, church groups, social agencies, civic groups, mothers' clubs etc. These are the people who must understand the need so that they can participate in a concerted public demand for such education. They also must be satisfied of the worth of the program so that they will not oppose it when the time comes to carry it out. (It is best that the whole program seem to be a response to their demands.)

Doctors are also presenting plans of study and suggesting methods of teaching. They are advising school nurses and physical education directors about methods of teaching. And, in many cases, they are offering their own services as instructors on a Junior High and Senior High School level and conducting classes for YMCA and YWCA groups and for church groups.

Also, medical auxiliary groups are working in many communities to make people aware of these needs and to help organize teaching programs. They are selling pamphlets at PTA meetings and public conferences and in many cases contributing financially to make appropriate printed material available in school libraries and in some classes.

State-wide

The State Maternal Health Committee has provided the impetus for publicity campaigns emphasizing the need for a uniform and integrated program in the schools.

During April and May, 1967, particularly, a special effort was made to present this cause over TV and radio, and the Governor of Michigan was prevailed upon to set aside a week in May as "Family Life Education Week."

Through state committee meetings and through the private efforts of individual members of the committee, this program has been under constant study and analysis, with the idea of presenting it for legislative consideration, for it will require special changes in Michigan law before a well-rounded program can be put into effect.

THIS PROMOTIONAL EFFORT has been carried out and supervised by a committee of physicians who call themselves the Lay Education Sub-committee of the Maternal Health Committee of the Michigan State Medical Society.

These men are enthusiastic and very sincere in their efforts, but they are not experts in the field of education or counselling. Therefore, it has been necessary to invite knowledgeable people to work with them as advisors and contacts. Such persons have been available to them through the Michigan Council of Churches, the Michigan State Medical Society Committee on Mental Health and Child Welfare, the Michigan State Department of Health, and the Michigan State Department of Education. Much help is also available from leaders in communities where such programs have already been initiated, both in Michigan and in other states as well. The publicity involved in the promotional activity has been carried out by the Public Relations Committee of the Michigan State Medical Society.

The contacts which we have tried to make throughout the state have been numerous — all the groups which are most likely to be interested in such a program, and all those which will be able to exert effective pressure on the schools or on the legislature in order to make possible a successful, coordinated and integrated state-wide program. Such contacts have been:

1. The medical profession — all pertinent committees, councillors, officers, auxiliaries.
2. State Government Officials
3. School organization:
    Michigan Congress of Parents and Teachers —also local PTA's
    Michigan Education Association
    Michigan School Health Association
    Michigan Association of Child Study Clubs
4. City and Civic Organization:
    YMCA and YWCA
    Michigan Youth Council
    Young Adult Council
    Service Clubs
    Community Recreation Departments
    Public Libraries
5. Michigan Council of Churches
6. Association of Sociologists and Psychologists
7. Health Careers Mobile

8. All media of communication — radio, TV, newspapers.

We have also encouraged local and area conferences on the need for Family Life Education, such as the one in Kalamazoo in December which was sponsored by the Council of Churches in conjunction with the Child Welfare Committee of the Michigan State Medical Society, the Kalamazoo Social Welfare Department and the Board of Education; and another in Petoskey, sponsored through local civic organizations and the local medical society. We have set up awards for the best community plans for Family Life Education programs and we have granted a special award to Mrs. George Romney for distinguished leadership in that field. We have also made use of promotional material from SEICUS and from the AMA.

THE FIRST THING that became apparent as we talked to interested groups was that we must do more than criticize and analyze — we must have a specific plan to offer. This plan is the principal feature of our Long Range Program, and it *must* be a plan adaptable to all school systems in the state.

This plan is not fully formulated at the present time. However, the basic principles on which it is based are those involved in the previously indicated definition of Family Life Education which cover the broad field of Information, Understanding, Etiquette and Self-evaluation.

We aim to develop this plan as a continuing experience to which the child is to be exposed from kindergarten through the 12th grade, and we hope to end up with a group of young people who have a knowledge of themselves, an understanding and appreciation of their place in society and in the community, who know how to behave themselves both according to the rules of etiquette and according to the standards of value which they have placed upon themselves, and who have discerned (as Phyllis McGinley points out) that "love is never merely a biological act but one of the few miracles left on earth, and that to use it cheaply is a sin." ("Province of the Heart," p. 37.) To do this we expect to make use of all known agencies working in this field and avail ourselves of the advice and assistance of experts in the educational field.

THE PRIMARY STUMBLING block is the apathy of local Boards of Education which are fearful of instituting such a program and are deterred by obsolete laws. We are continuing to work to create a local realization, both in the public mind and in the Board of Education, of the need and desirability for this kind of education.

So we are working first on a plan to present to the State Legislature and we are urging special training in this field as a requirement for a degree in Education.

Meanwhile, we seek to introduce as much as possible of this subject matter into the present school program. The easiest way to begin this is through printed material and movies and through the use of some of our experts as guest speakers or occasional voluntary instructors. Fortunately, there is a good measure of teaching material available through SEICUS, AMA and state and local medical societies. Pamphlets, charts, manikins are offered both for school use and for adult groups. We are also encouraging in-service training and extension courses for any of our present teachers who are willing to participate.

The MSMS Committee assisted by consultants, will aggressively push its short range planning and long range planning this coming year.

NATIONAL CONFERENCE AIDS SCHOOL HEALTH

The 11th AMA Conference on Physicians and Schools, held in Chicago in October, an interdisciplinary meeting designed to promote school health in its broadest definition. At the invitational meeting were included government, various school agencies at the primary, secondary and collegiate levels, physicians, social workers, psychologists and public health workers. Registration was 325.

Michigan was well represented including Doctors Mary S. Bitner, Edwin C. Galsterer and Louis E. Heideman, MSMS members. Other Michigan registrants included Dr. Paul Hunsacker, Dr. Margaret S. Large, Dr. Joseph J. Dzenowheis, Dr. Gertrude B. Couch, Dr. Mabel E. Rugen and Mr. Don Pangborn. A number of former Michiganders were also in attendance.

The general topic of the meeting was "School Health in Action," developed by a number of panel presentations with workshops. In the keynote address Delbert Oberteuffer, Ph.D., on "Health Education and Education — An Appraisal — II," compared the current state of health education programs to that four years ago, noting significant progress but many persisting areas of deficiency. Panels were entitled "Current Health Problems," "A Variety of Methods in Health Education," "School and College Relationships," "Family Life Education," and "Research and Health Problems."

Retropubic Cross-Over Graft For Unilateral Aorto-iliac Occlusive Disease

BY JOHN L. SHEK, M.D.
CARLOS C. SORIANO, M.D.
BOTH OF SAGINAW

ABSTRACT—A report of five case histories of successful cross-over retropubic extraperitoneal bypass graft for unilateral disease of aorto-iliac system. Its advantage as a less risky procedure is stressed and a plea for proper evaluation of its inclusion in the overall arterial surgery by increased usage is entered.

The position of bypass graft in the treatment of arteriosclerotic occlusion disease has long been recognized. Reports of successful large series of cases from major centers have encouraged and established its application in many community hospitals where competent surgeons and adequate facilities were available. The indication for this procedure and for its employment has also become more or less non-controversial.

However, there are situations of unilateral obstructive lesions of the aorto-iliac system in which one finds the usually preferred aorto-iliac or aorto-femoral Y-graft bypass, necessary for its alleviation, to be contraindicated. The magnitude of this procedure is undeniable and its operative risk in a systemically diseased person could be prohibitive. However, the procedure of retropubic cross-over iliac to iliac bypass straight graft, which might accomplish the same result, could be done with much less surgical trauma.

By virtue of obviating exteriorization of intestine in the extraperitoneal approach, avoidance of disturbance to aortic bifurcation area, and lower abdominal incisions, it is felt that in certain circumstances this procedure deserves serious consideration in preference to the standard bifurcation graft.

The purpose of this report is to record five successful case histories to confirm and emphasize the usefulness of this cross-over procedure.

CASE 1.—H.E.S. This is a 74-year-old white female who entered St. Luke's Hospital with a painful ulceration of the right foot and discoloration of right leg to below knee area. Approximately 3 weeks prior to admission she began having pain, whiteness and then swelling to the right 1st, 2nd and 3rd toes, which gradually increased in severity up to the time of her admission. Being an amputee, patient has no experience of intermittent claudication. She had rest pain of right ankle for 2 years.

This woman has a long standing history of peripheral vascular occlusive disease of both lower extremities. In 1961 she underwent a laparotomy for surgical excision of an abdominal aneurysm involving the lower third of the abdominal aorta and insertion of aorto-iliac Y-graft. On 2/8/62 a bunionectomy was done on her left foot. Her postoperative course was poor in that the wound did not heal over entirely. She was readmitted to the hospital on 11/4/62 because of a large, necrotic ulcer on the medial aspect of the left foot which appeared to be involving the first metatarsal. Ankle pulse was not palpable on either extremity nor were the popliteal pulses palpable. A low leg left amputation was done on 11/8/62 with a postoperative diagnosis of arteriosclerotic gangrene of left foot.

The patient states that she has hearing difficulty bilaterally. She has more difficulty in seeing out of the left eye in which there is a lateral rectus weakness. No other pertinent findings noted in the review of systems.

Physical examination revealed a well developed, fairly nourished, elderly female with pain in the right foot. Vital signs were within normal limits with a blood pressure of 160/60. There is inward rotation of the left eye due to lateral rectus weakness of the eye. Silver wiring effect on fundoscopic examination. Heart examination revealed systolic and diastolic murmurs, the diastolic radiating to the aortic area. Pulmonic sound is greater than the aortic sound. Point of maximum impulse is diffuse. The extremities showed a left foot amputation. The right foot revealed the toes to be gangrenous. There is an ulcer on the lateral surface of the right foot over the dorsalis pedis area. The dorsalis pedis pulses are not felt on the right. The leg is cold from approximately 2 inches above the right ankle to the knee. EKG shows left ventricular hypertrophy and myocardial ischemia.

Laboratory findings are within normal limits.

A right sympathetic nerve block was done which did not improve the circulation. Aortogram showed irregularity in the lumen of the aorta extending into the course of the left iliac artery. The right iliac does not visualize. Some collateral circulation can be identified about both hip joints. An extraperitoneal bypass cross-over procedure was done connecting the left external iliac to the right external iliac. Post operatively, good circulation was obtained in the right lower extremity, except for the area involving the toes. A below-knee amputation was done. Her post-operative course was excellent and uneventful and she was discharged.

Comment: It is apparent to all who have the opportunity to re-operate over a previously grafted area that the dissection is extremely tedious if not dangerous due to the adhesions in the area. This patient, who has had an abdominal aortic aneurysm resected and a Y-graft inserted six years ago, would most likely have the area tightly bound down by adhesions. This cross-over procedure was done successfully in a virgin area. It is believed that this has salvaged her knee joint as otherwise an above knee amputation would have been necessary. To a person who would become a bilateral amputee the benefit is therefore apparent.

CASE 2—E.J. This 63-year-old male was admitted to the hospital for the 5th time because of acute shortness of breath and "abdominal angina." He was a known "chronic lunger" since 1952. Had a right lower lobe lobectomy in May of 1959 for chronic bronchiectasis. Diagnosis of emphysema was made at that time also. In 6-66, while he was suffering from acute pneumonic process in the hospital, an embolectomy of his right iliac artery had to be done. During the present hospitalization, X-ray shows progressive deterioration of emphysema and the left ventricular hypertrophy and passive pulmonary congestion. Patient had continuou night pain of his right lower limb from the thigh down and has worsened to the extent that large doses of narcotics were necessary for its relief. Intensive therapy was directed towards his respiratory and cardiac decompensation. The "abdominal angina" was treated by anticoagulation.

After a period of about 4 weeks the patient was more or less stabilized as far as his cardio-pulmonary system is concerned. The "abdominal angina" was also relieved, but he has lost 10 lbs. of body weight. However, the rest pain of the right lower limb further deteriorated as evidenced by signs of acute ischemia, discoloration and absence of popliteal and ankle pulsation. It became imperative that surgical relief has to be seriously considered. An aortogram was done which showed non-visualization of the right iliac artery with faint delineation of deep femoral artery.

Because of the extremely poor condition of this patient it was not felt that he could withstand an aorto-iliac bypass graft. Accordingly, an extraperitoneal left iliac to right iliac cross-over bypass graft was done. The patient had a smooth post operative course and the severe night ischemic pain of the lower limb was relieved. A 1+ pulsation of posterior tibial was present and the patient when last seen was able to walk 1 block without claudication.

Comment: The increased operative risk in this patient should be quite evident and yet the severe and continuous rest pain of the entire right lower limb with impending gangrene of the toes demanded consideration of surgical relief. It is also felt that this patient might not have tolerated a midthigh amputation as well as this cross-over bypass graft.

CASE 3—G.F. This is a 78-year-old white male admitted to the hospital because of severe ischemic pain of the entire right lower limb and dry gan-

AUTHORS

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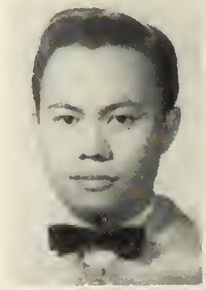

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SORIANO

grene of the toes up to the metatarsal. He survived a severe cerebral vascular accident 4 years earlier. However, his mentality was reduced to that of a child. The laboratory findings were essentially normal. EKG showed ventricular hypertrophy. Chest X-ray revealed arteriosclerotic changes and a tortuosity of the aorta and enlarged heart. Lungs showed some senile emphysema. Physical examination revealed a well developed and well nourished white male of the stated age with no cardiorespiratory embarrassment. Mentally sluggish but able to answer questions intelligently. Mentality estimated to be that of a 10-year-old. Likes to have his meals fed by his wife. Neck veins not distended. Chest is free. Lungs clear. Heart with loud systolic murmur over the aortic area. Abdomen negative. Extremities negative except for the right lower limb where there is no femoral or ankle pulses. The right lower foot is gangrenous up to the metatarsal area.

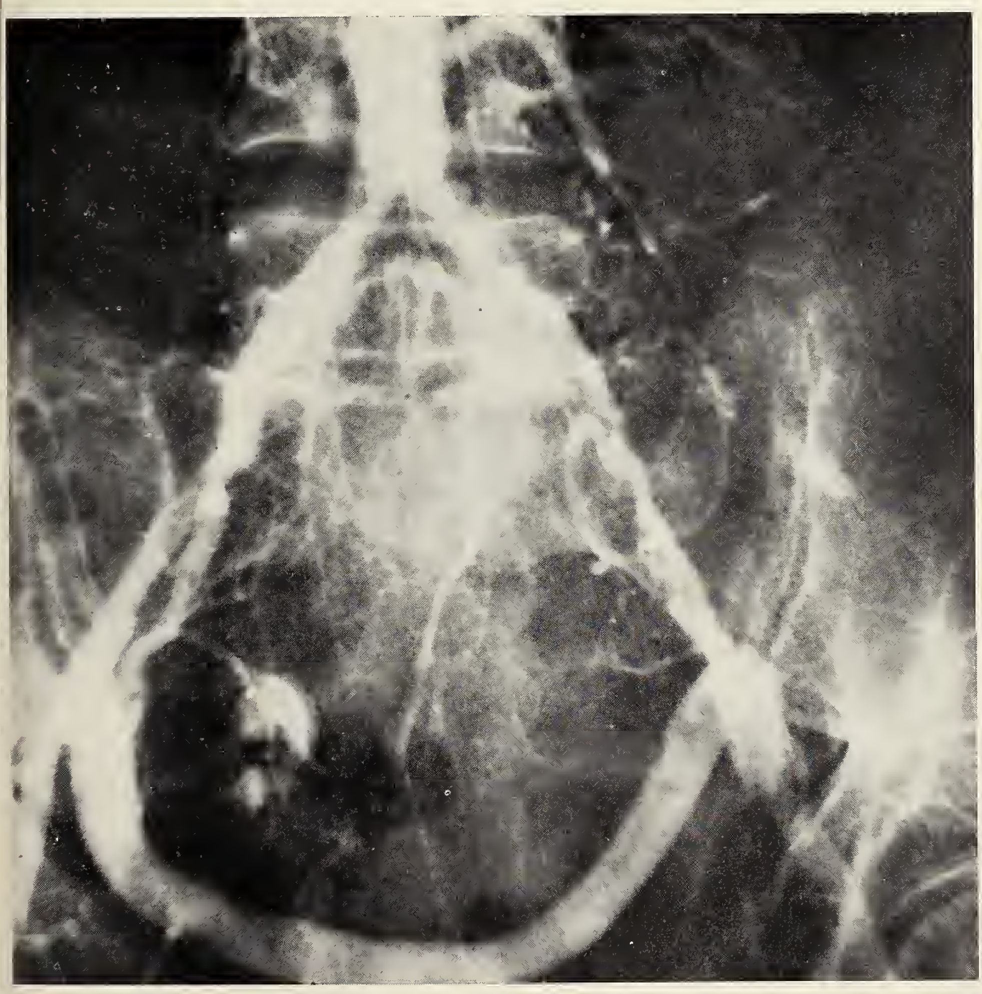
An aortogram was done and it showed complete occlusion of the right common iliac artery and arteriosclerotic changes of the rest of the aorto-iliac systems. However, there is definite 3+ pulsation of the left femoral artery. A retropubic extraperitoneal cross-over left to right iliac artery bypass graft was done. Postoperatively the right femoral pulse was present, 2+. The severe rest pain was relieved. While we were trying to convince patient and his wife of the necessity of a transmetatarsal amputation of the gangrenous toes, the patient had another CVA and expired.

Comment: Although the patient died from a recurrence of a cerebral vascular accident, the relief of ischemic pain before the final demise was accomplished. The patient and his family were spared from the amputation which they had strenuously resisted.

CASE 4—W.G. This is a 67-year-old white male admitted to St. Luke's Hospital because of pain in the left groin radiating down the left leg posteriorly to the knee on walking any considerable length and accompanied by moderate cramps in both legs and feet.

Review of systems showed no pertinent findings. Smokes ciragettes excessively and drinks moderately.

Mother deceased at age 93 and had gangrene of



The photograph shows the patent graft connecting both iliac arteries with the proper angulation at the anastomatic sites.

the leg. Father died at age of 60, cause was posterior myocardial infarction.

Physican examination showed bruits over both carotids. Heart exam showed mitral murmur, systolic in nature. Lower extremities showed absence of left femoral pulsation and anterior and posterior tibial pulses not palpable on the left. On the right femoral pulsation, 4+ and posterior tibial pulse is palpated easily, the anterior tibial palpated with some difficulty.

Laboratory findings showed no pertinent findings. Chest X-ray revealed sclerotic plaque in the aorta. Lungs show some senile emphysematous changes.

Aortogram done at this time revealed arteriosclerotic occlusive disease on the left aorto-iliac system. An extraperitoneal retropubic right iliac to left iliac cross-over bypass graft was done. The patient had an uneventful recovery. Left femoral pulsation now is 3+ with 2+ posterior tibial pulsation. There is now no rest pain and able to walk four blocks and no claudication.

Comment: The smooth post operative course with only two weeks of total convalescence is believed to be preferred to a longer period of post operative morbidity and limitation as is usually the case in a midline incision and a Y-graft. (See photograph)

CASE 5—C.A. This is a 66-year-old white male, who was admitted to Saginaw General Hospital with a history of claudication pain in the left leg starting at the hip and extending to his toes. The patient noted approximately walking 1 block that he suffers from this type of pain and this is progressive in nature and within the last 15 days he is only able to walk about ½ block. This whole pain is confined to his left leg. He denied any history of impotence, previous history of heart attack, anginal pain. Denies any vascular type of headache or any other cardio-vascular type of symptoms.

Review of Systems: Noncontributory. He hasn't complained of shortness of breath, cough, or chest pain.

Past History: A transurethral resection 3 years ago. BP 120/80

Physical examination revealed patient to be well-developed, well-nourished, cooperative, in no apparent cardio-respiratory distress. Head and its organs, essentially negative. Chest, lungs were normal on auscultation and percussion. Heart showed normal sinus rhythm with 81,82 normal. No cardiomegaly noted. No murmur was heard. Abdomen, free of any masses or any organomegaly. Back and spine were found to be negative. Extremities, weak femoral pulses 3+ on the right side, and no femoral pulses on the left side. Ankle pulses present in the right, 3+, and only ± posterior tibial on the left. No discoloration noted Neurological examination, negative.

Laboratory findings essentially within normal limits. EKG normal. Chest films showed arteriosclerotic changes of aortic knob. Lumbar aortogram shows aorto-iliac system to be diseased and almost 90% occlusive of left common iliac artery. Good delineation of femoral arteries bilaterally. A retropubic cross-over iliac to iliac bypass graft was done. Post operative course smooth and a post operative aortogram shows "good flow." Femoral pulsation in the left is 3+ and ankle pulsation restored to 3+. Patient is now asymptomatic.

Comment: In line with the thought that reoperation over a grafted area is usually more tedious and thus difficult, one wonders whether a straight aorto-iliac bypass graft is necessary if a cross-over graft in the iliac region could serve the same purpose.

Technique

The technique is nothing unusual. Under general anesthetic, patient is surgically prepared and draped. An oblique incision was made over the inguinal area down to the external oblique fascia. The internal oblique and transversus muscles were traversed to incise the transversalis fascia in order to reach the retroperitoneal space. The arteries were then freed accordingly. The space of Retzius was found to be easily entered into and the graft could be tunneled with no difficulty. An adequate amount of laxity between the graft and the artery is necessary as well as proper angulation for the end to side anastomosis. The wound is reapproximated in the usual fashion.

Conclusion

From the five case reports listed above, when there is a definite indication that calls for a less risky procedure to accomplish the end of increased circulation, it is believed that this cross-over retropubic extraperitoneal bypass graft should be given more of a trial to ascertain its exact usefulness in the overall armamentarium of arterial surgery. It would also lead one to feel that in cases of unilateral disease of aorto-iliac system it might be justified to attempt to preserve the area unmolested for any future operation that has to be done in that area.

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Are You Preventing Erythroblastosis?

JOHN E. DOOLITTLE, M.D.
NILES

Approximately 5,000 infants succumb to erythroblastosis fetalis in the United States each year, with intrauterine and neonatal deaths almost equally represented. If by any means this cause of perinatal mortality could be eliminated, the resultant total infant mortality rate would be close to 20 per 1,000 live births, a figure recently claimed by several European countries[1].

An improvement in such statistics would be a credit to U. S. physicians, but more importantly, prevention of the disease would eliminate the near-deaths and tragic end-results of kernicterus, which, to the family concerned are many times more significant than any statistics.

At present there are two approaches that can be utilized in preventing erythroblastosis fetalis. The first, to be described in this paper, is based on a study of basic principles and phenomena occurring at the time of delivery. The second utilizes human anti-D globulin obtained from volunteers, administered to Rh negative mothers shortly after delivery, attempting to destroy any Rh positive cells that gained access to the maternal blood stream during delivery[2].

IN ORDER TO BETTER understand the two techniques, it would be wise to delineate the basic principles involved. It is quite agreed that erythroblastosis fetalis results from a small transfusion of fetal blood, Rh positive or otherwise incompatible with the mother's blood, and that such transfusions usually occur at the time of delivery. Primipara seldom deliver affected babies and seldom develop any antibodies during their first pregnancy—a fact which speaks well of the barrier between maternal and fetal blood streams. In fact, the incidence of maternal sensitization jumps 2,000% from primipara to multipara[3], which indicates that sensitization during a pregnancy is extremely rare.

That fetomaternal transfusions occur at delivery has been well documented[4,5] by various investigative techniques. The development of sensitization following such fetomaternal transfusion has also been documented[4,6] and shown to be clearly related to "dosage"—i.e., the larger the transfusion, the greater the chances for maternal sensitization. Several studies have shown increased transfusions following manual removal of the placenta and at cesarean sections and this is to be expected as the maternal vessels are exposed to a larger amount of fetal blood escaping from the traumatized placenta.

The mechanism behind such escape of blood has been delineated[7], and is simply a matter of "leaky plumbing." The placental vessels pre-delivery are intact and essentially leak-proof but at the time of placental delivery, many small capillaries are broken, allowing fetal blood to escape into the maternal veins. The vascular defects that allow such leakage have been demonstrated and shown to occur in approximately 25% of deliveries[7], a statistic that is indirectly corroborated by large retrospective series revealing sensitization percentages of 25% in the second, third, fourth, and fifth pregnancies. In other words, a patient has an equal chance of being sensitized in the second through fifth pregnancies—*if she is to be sensitized*[3].

THE OBSTETRICIAN DEVELOPS a routine for delivery which often includes one or more of the following procedures: 1. Intravenous Pitocin is given at the delivery of the anterior shoulder. 2. Two clamps are placed on the umbilical cord and the latter divided. 3. In delivering the placenta, moderate cord traction may be utilized. *THESE THREE TECHNIQUES SHOULD NOT BE USED* except in unusual circumstances.

If an effort is made to prevent fetomaternal

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DOCTOR DOOLITTLE

transfusions, then it follows that one must decrease the amount of fetal blood in the placenta and handle the third stage in such manner as to minimize the possibility of producing small vascular defects in the placenta. So logically handled, the placenta should be emptied as soon as the umbilical cord is available—placing only one clamp on the fetal side. As the placental blood is draining from the proximal end of the cord, a sample can be collected for the necessary blood studies. Care must be taken to avoid exsanguinating a twin. This is easily prevented by palpating the fundus before dividing the cord.

It takes time to deliver the baby and divide the cord, so intravenous Pitocin *should not be used* "with the shoulder," as the resultant hastened uterine contraction expels fetus and placenta all too often, leaving no time to exsanguinate the placenta.

In delivering the placenta every caution should be taken to deliver it as intact as possible, which dictates that cord traction and manual removal are not to be used, as these procedures result in minute tears in the placental capillaries, which in turn can ooze small amounts of retained fetal blood into the mother.

THE THREE STEPS just described have been used in clinical practice, with the results previously summarized[8], revealing a marked decrease in sensitization. 153 Rh negative mothers with Rh positive infants were studied and only 2 developed sensitization postpartum, approximately $\frac{1}{10}$th the expected incidence. The technique has continued to be effective in reducing maternal sensitization, and at this writing 184 infants have been delivered using the "three-step" technique, with no additional patients developing sensitization (1.0% in contrast to the expected 9.2%). Sensitization is detected by repeating the indirect Coombs test on the mother at 6-8 weeks postpartum.

The three-step technique is universally applicable, regardless of antigen type, and is contraindicated only during twin delivery. Infants delivered in this manner have done well, with no detriment in the Apgar score or clinical course. Recent papers have confirmed the safety of early clamping of the cord even on prematures[9]. The three-step technique requires no special instruments, no special training, and no expense to the patient or hospital.

A brief note should be included regarding the immunization technique presently being studied at several centers. The injection of anti-D globulin into the mother with known fetomaternal transfusion has resulted in no demonstrable sensitization[2]. The injectable antibody is very specific, i.e., anti-D, therefore not helpful in cases of other than D sensitization. A recent paper states that ⅓ o antibodies found in sensitized mothers are othe than D, so a vast array of injectables would hav to be manufactured to meet the needs of patient sensitized to the less common antigens[10].

AND A BIG QUESTION remains to be answered concerning the administration of anti- globulin—does it really prevent or cancel out sensitization, or is a laboratory artifact resultin which appears to be clinically effective? The possibility exists that the injected globulin may linge in the maternal blood stream, perhaps on the maternal red cells, to combine with the Coombs reagent (anti-human globulin), resulting in a fals negative Coombs test. Time will tell whether thi is theory or fact.

Summary

1. The mechanism of sensitization leading t erythroblastosis fetalis is reviewed.

2. A simple, effective plan for preventing sensitization is described, resulting in a marked decrease in maternal sensitization.

3. A plea is made for obstetricians to chang some of their "delivery routines," in order to avoi iatrogenic sensitization.

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Blames "Disgraceful Shortage of Doctors" On Lack of Stable Financial Support

"The nation's shortage of doctors and of schools o train them is disgraceful and intolerable in a ountry that prides itself on opportunity for its outh and has committed itself as a matter of naional policy to providing for the health of the eople."

So declared William N. Hubbard, Jr., M.D., University of Michigan dean of medicine, in his ddress as president of the Association of Amerian Medical Colleges at the recent national conention in New York.

"Although the size of medical schools has been limited in part by the theory of optimum class size, the limitation is principally a lack of stable financial support for the education program itself," Dean Hubbard said.

At present, he said, competent students are turned away from medical schools because the schools cannot handle them. At the same time, schools are producing far too few graduates to meet even minimal demands.

The tension between education and meeting health needs "can serve as a stimulus for change, but probably cannot and should not be nullified by making one concept altogether subservient to the other. Rather we must expect a shifting state of dynamic equilibrium between these two ideas."

Public concern with the education of physicians has arisen because of "the increased effectiveness of the health care system and its enlarged importance to the general welfare of the people," Dean Hubbard said.

Dean Hubbard declared that "medical education today is confronted with its unique responsibility for educating the medical student and simultaneously fulfilling the elevated health goals of the people. It is the student physician who must be the primary object of concern."

The U-M dean stressed that medical schools have "responded to the powerful effects of expanding knowledge through specialization, institutionalization, the development of the concept of the health team, and an increasing professionalization. But it has not increased in size enough to meet demands for increased manpower.

"As practice has improved, its value to the individual and to society has been recognized and there is now a demand for universal availability of health services," Doctor Hubbard said.

"This demand is so large that it requires an appraisal of how much of our gross national product is optimally spent on the health care system. As the total system for providing health services moves from the realm of pure private enterprise to something analogous to a public utility, the need for some expenditure-limiting mechanism as

What Are Pressing Issues Facing Medical Education?

In his Presidential Address to the Association of American Medical Colleges, U-M Dean Hubbard suggested the following "most pressing issues regarding physician education:"

1. The number of physicians.
2. The problem of bringing to actual practice the undisputed assertion that a doctor's education is lifelong.
3. The excessive length of the formal education in schools and hospitals.
4. The need for vertical reorganization of the medical curriculum.
5. The need for resynthesis in teaching. "For the medical student, the significance of descriptions at the molecular and submolecular level must be presented in the context of their relationship to the more complex organizations of these same living systems at the level of the organ, the individual, and the family group."
6. The need for the curriculum to help the student physician understand his future role as a leader of the health care team.

a substitute for the bygone limits of charitable contributions on the one hand and the economically sufficient purchase on the other must be developed."

Pointing out that the increasing size of the population and the growth of the younger and older segments exaggerate the rate of public demand for health services. Doctor Hubbard said: "The economic effectiveness of this demand concludes the argument that in a capitalist democratic society where there is a general and growing public demand backed by the money to pay, then the only question that remains is how the demand will be satisfied rather than whether it will be done."

Human health goals today go far beyond the primitive notion of simple survival, he said. Most efforts in the past 20 years have been devoted to the prevention of premature death.

"For the future, we must address ourselves to the ultimate goal of optimum health as an essential ingredient of the fulfillment of each human's potential."

Dean Hubbard asserted that the development of the health-care system is being limited by shortages of professional manpower for research, education, and service.

"The forward thrust of the system is being driven hard at two levels—the development of scientific knowledge through research and the demand for the universal availability of health service. Unless equivalent support is made available to eductaion so that this new knowledge can be applied to practice, then much of the public benefit of research will be delayed and expectations for extended health service will be doomed to disappointment."

The academic medical center "is today our society's prime source of professional manpower, new knowledge, and new technology related to health," the medical educator said. "An urgent question for our time is whether an academic medical center should develop some quantitative relationship between its distribution of efforts in education, research and service."

"The response to problems in medical education must become the first call on the time and attention of our faculties of medicine. The unique and inalienable responsibility of a medical faculty to the society that supports it is for the conduct of the curriculum that leads to the M.D. degree," Dr. Hubbard said.

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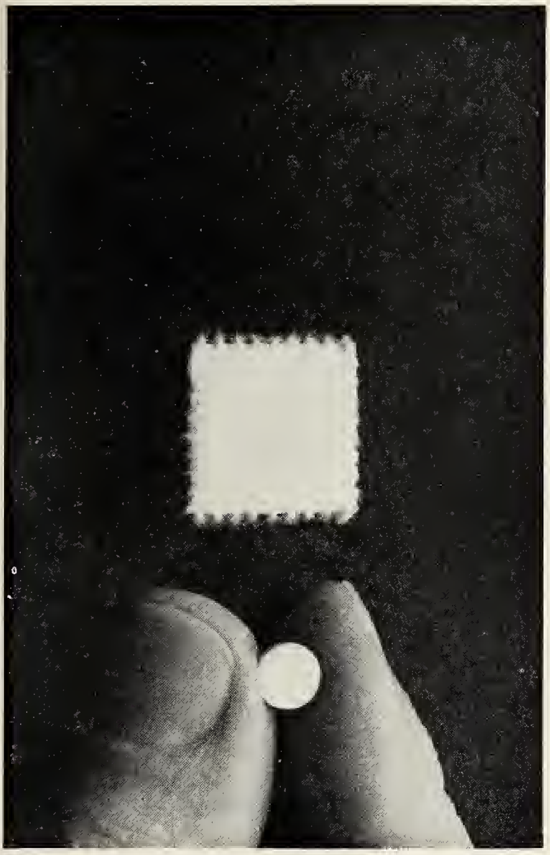

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SAYS INFORMATION FLOW SYSTEMS NEEDED IN MEDICAL FIELD

Information flow is the key to the problem of organization facing American medicine, according to the United States Surgeon General, William H. Stewart, M.D., speaking at the recent meeting of the National Academy of Engineering at the University of Michigan.

Calling the "crisis in American medicine today" essentially a "crisis of organization," he said, we "cannot afford to go on thinking of physicians, or hospitals, or public services, as worlds apart." Information flow featuring systems with inputs, outputs, and feedbacks that truly reflect needs and relate resources to those needs should be designed. This, Doctor Stewart said, "has been done with other large and complex management problems" and is "essentially a task for the engineer working as a full partner in the health enterprise."

The greatest contribution of engineering to medicine over the next thirty years, according to Surgeon General Stewart, may well be in data processing and communications. "Well within the range of capability," he continued, "are such enormous undertakings as medical records systems for a city, state, or region."

Doctor Stewart continued, saying that he does not "see the individual human being sinking deeper and deeper until he is finally lost in a collectivized, computerized heaven or hell. Rather, I stubbornly believe that our remarkable technology can be placed at the service of mankind, provided we keep our eye not only on mankind, but on the individual man and woman and child seeking their highest fulfillment."

On another subject, the Surgeon General stated that we know how to remove a great many disease and accident risks from our surroundings, but we "lack the firm social decision to do it."

DISPLAY OF SCIENCE LITERATURE UNDERWAY

A current literature display on information science and technology is being prepared under a grant of $15,900 from the National Science Foundation awarded to the Special Libraries Association. The work will be conducted under the supervision of the Documentation Group of the New York Chapter of SLA, originators of the proposal.

The basis for the collection is volume two of the *Annual Review of Information Science and Technology,* to be published in the fall.

Partners with AMA in Communicating

State Medical Journals Help To Meet the Challenges of Today

BY LEO E. BROWN

Never before in the history of man has organized medicine been criticized so severely as today. The organized efforts to discredit medicine are well known and well financed. The end is not in sight. As a matter of fact, these attacks and innuendos of gross overcharging and incompetent service can be expected to increase as the financial pressures of Medicare and Medicaid become more acute.

State medical journals must enter this fray by devoting additional pages to informing the profession of these attacks and in providing them with facts to be used in discussions with their patients.

As key communicators in this struggle, state medical journals can become even more important to organized medicine.

MEDICAL COMMUNICATIONS probably had its ancient origin in the cuneiform tablets of Sumeria, inscribed thousands of years before the code of Hammurabi. The medical writings inscribed on Egyptian papyri, contributions of the Persian priests, Hippocratic collection, and the 400 authoritarian books of Galen probably started medicine off in what now has become the greatest plethora of medical information ever imposed on mankind.

It is estimated that there are some 4,000 medical journals published in the world today. The AMA library alone utilizes the resources of 2,200 medical journals and 40,000 books. And there are millions of pieces of direct mail bombarding the physicians from the pharmaceutical industry.

There is little wonder that the physician becomes frustrated and develops a feeling of resistance toward all forms of medical communications.

And in all of this melee of medical communications, where does the state medical journal fit into the physician's reading habits and of what importance are these journals to organized medicine?

In discussing the importance of state medical journals to organized medicine, I think it is fair to say that state medical journals constitute not only the traditional but the most accepted method of communicating with the total membership of a state medical association. It is an accepted fact that the strength of the American Medical Association is dependent on the vitality of its constituent state and county medical associations. The importance of the state medical journals to the American Medical Association is directly proportionate to the position of importance in which each journal is held by the physician receiving it.

State medical journals are important to the AMA and organized medicine in a variety of ways. First and foremost, they constitute a very important unifying factor within medicine. They serve as the primary communication medium between the state medical association and the individual physician. They provide each physician on a regular basis important information on the state association's scientific and socio-economic programs and activities. They keep the physician informed of the contributions being made by medicine and the problem areas which demand serious consideration. They provide a regular important link between the practicing physician and organized medicine. They keep him informed on local happenings within the family of physicians practicing within each respective state or geographic area.

STATE MEDICAL JOURNALS serve many more useful purposes insofar as organized medicine is concerned, but to be more direct—how do state journals serve the American Medical Association?

Here again they serve in direct proportion to the attitude of the editor insofar as his interpretation of the role of his journal plays as a communication arm of organized medicine, including both the specialty medical society and the AMA.

State journals can and do help impress upon the physicians the leadership and services available through the AMA.

Together, we must meet the challenges of the times. But this can be done only if we have an informed profession dedicated to serve the best interests of each patient.

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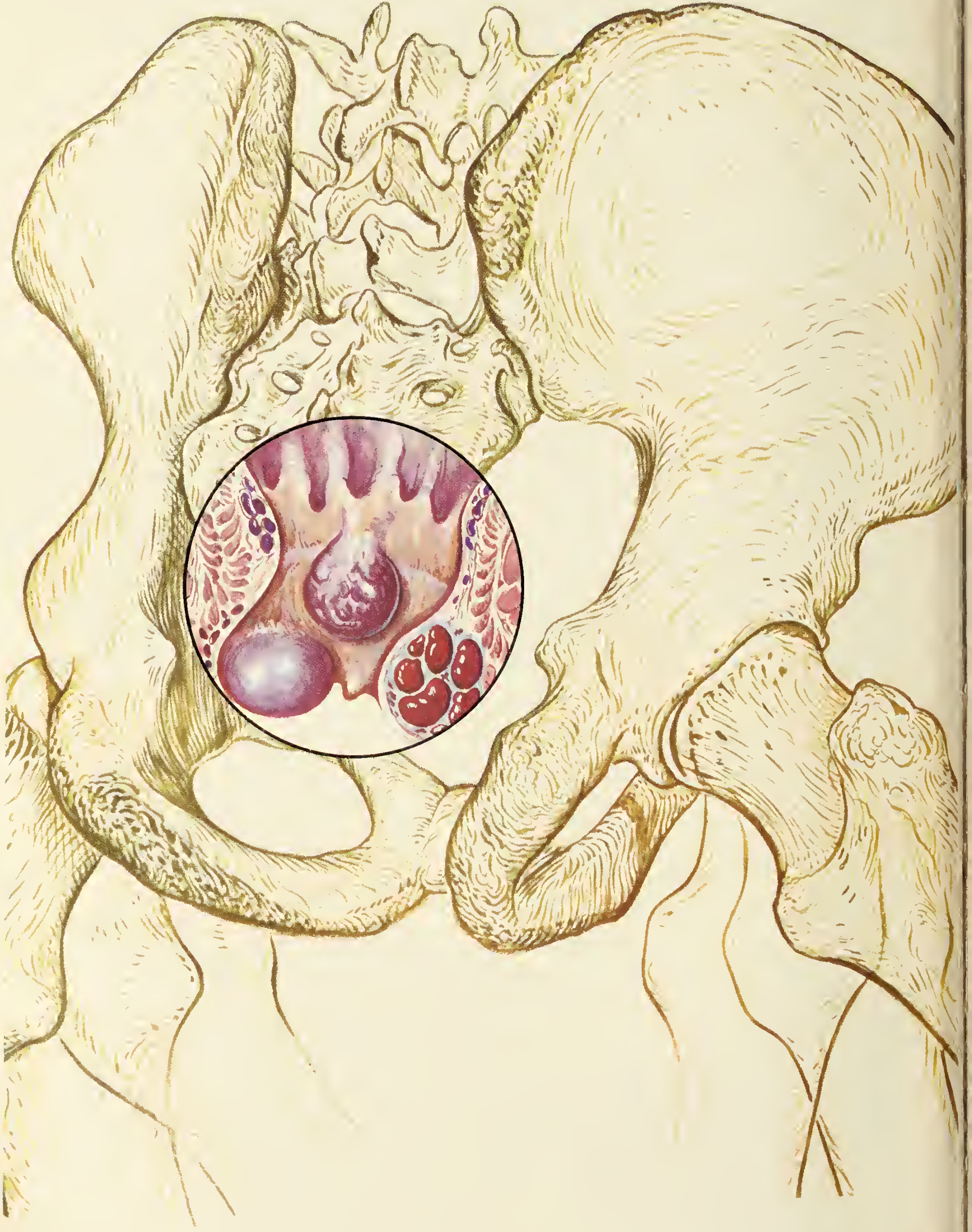
For the ambulant patient with hemorrh



. . . METAMUCIL®

brand of psyllium hydrophilic mucilloid

Relieves strain

Metamucil produces soft, well-formed stools that minimize pain and strain and reduce the chance of thrombosis in hemorrhoidal veins.

Softens stools

Metamucil, a highly purified vegetable colloid, absorbs water, hydrates the intestinal contents and produces a demulcent "smoothage" that aids healing of hemorrhoids and anal fissures.

Reduces pain

Metamucil reduces pain by eliminating the abrasive irritation of hard, dry stools.

Restores bowel function

Metamucil produces a gentle distention of the intestinal wall that stimulates natural peristalsis and helps reestablish normal, rhythmic bowel function.

And in constipation...

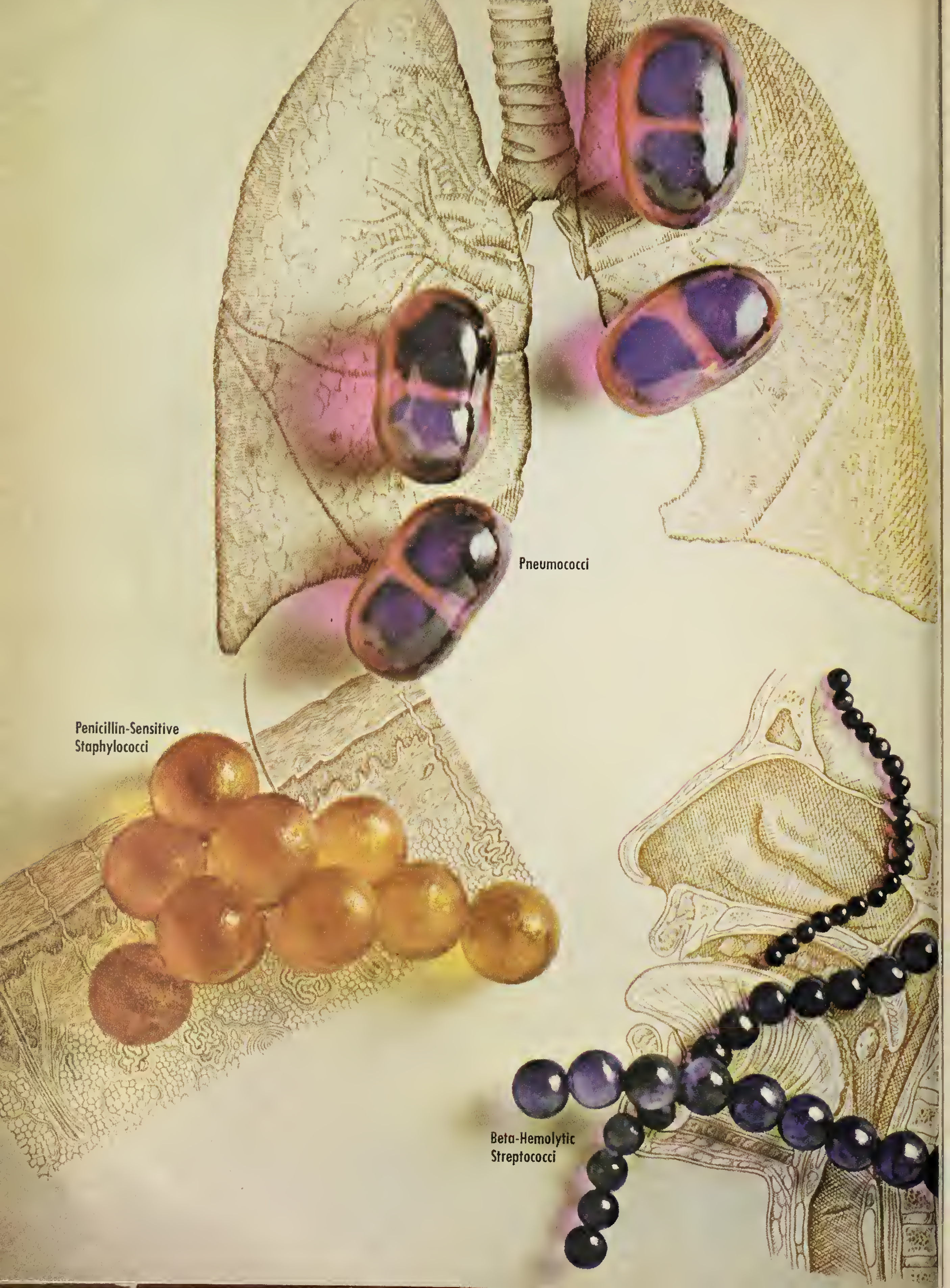
Metamucil furnishes, as it has for more than 30 years, the simple physiologic corrective to constipation, eliminating both hard stools and the need for harsh laxatives.

Usual Adult Dosage:

One rounded teaspoonful of Metamucil powder in a glass of cool liquid, or one packet of Instant Mix Metamucil in a glass of water. An additional glass of liquid is helpful.

SEARLE *Research in the Service of Medicine*

Against these three major pathogens…


Pneumococci
Penicillin-Sensitive Staphylococci
Beta-Hemolytic Streptococci

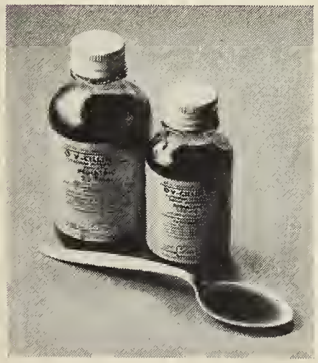
V-Cillin K® provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.



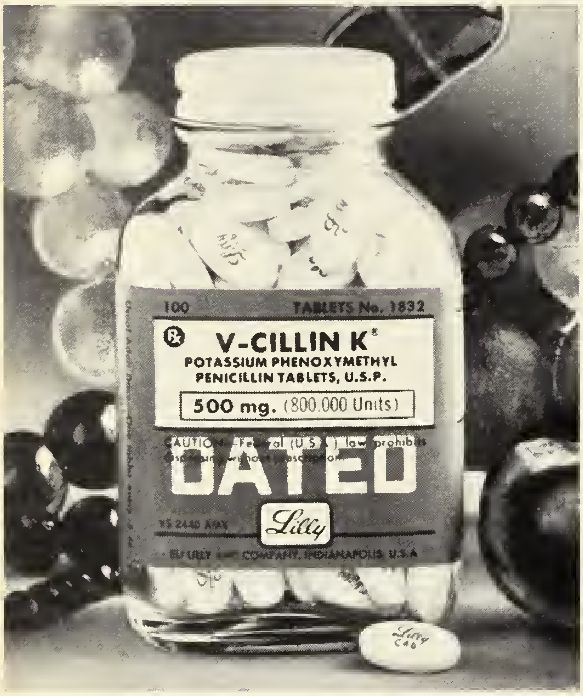
V-Cillin K® Lilly 701449

Potassium Phenoxymethyl Penicillin

Now available: V-Cillin K®, Pediatric, for Oral Solution, 250 mg. (400,000 units) per 5 cc. of solution.

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses


100
TABLETS No. 1832
V-CILLIN K
POTASSIUM PHENOXYMETHYL
PENICILLIN TABLETS, U.S.P.
500 mg. (800,000 Units)
CAUTION—Federal (U.S.A.) law prohibits dispensing without prescription
DATED
Lilly
ELI LILLY AND COMPANY, INDIANAPOLIS, U.S.A.

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

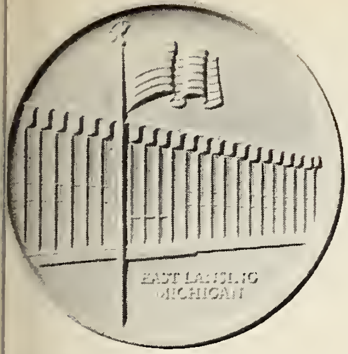
How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

701449



What Is Current Thrust Of MSMS In Science, In Medicine . . . And How Is MSMS Doing?

"Where Does MSMS Stand" is the provocative question asked in a new MSMS workbook by the same name and now being studied by members of The MSMS Council and by the Delegates.

Thirteen different subject areas are covered. Each of these is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The November issue of *Michigan Medicine,* on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed the November issue are invited to go back and read it. The November article promised to print parts of the "Where We Stand" publication in future issues.

The first two subjects discussed in the booklet are reprinted in this December issue and other material will follow.

SCIENCE

Discussion

Financial Support of
Scientific Research
National Institutes
of Health
Pharmaceutical
Manufacturers

The MSMS financially supports no medical scientific research other than that carried out by the AMA. However, the tax money of its members is used in the work of the National Institutes of Health, said to be responsible for some 90 percent of the monies used in the United States for medical scientific research. Some of this research is done in Michigan medical schools. Also, at least two major Michigan pharmaceutical manufacturers are conducting scientific and technological research in the health field. Michigan doctors have participated in local, statewide, national, and international research programs, often with the policy support and active cooperation of the MSMS.

Scientific Research
Participation

At the moment no medical scientific effort directly conducted by MSMS is planned, and indeed such is unlikely. But this does not mean that MSMS or its members cannot or should not *participate* in medical scientific research. Quite the contrary, some of the most exciting work could be accomplished either by a formal plan or an informal program which is aimed toward seeking means of putting new scientific breakthroughs to use, and of evaluating their effect upon the total practice of medicine, upon medicine's specialties, and upon the cost and upon the availability of medical care.

Impact of Research on Practice
Polio Vaccine

Michigan physicians will recall the episodes which occurred here when a polio vaccine was tested, again when another polio vaccine was given free to millions, again when a rubeola vaccine became available and then when it too was given free to thousands of children. These were dramatic examples of the impact of medical scientific research developments upon the daily practice of medicine . . . *when such research becomes* known to the public. And today such information is instantly transmitted to a people that are hungry for every new developmen that might contribute to their health.

Rubeola Vaccine Campaign

In the case of the measles vaccine, MSMS received far better quality results and recognition than it did in the earlier polio situations. The Society immediately upon the discovery and issuance of a suitable rubeola vaccine conducted a massive statewide educational campaign to tell of the opportunities now available and get people to go to their doctor's office for measles immunizations. It wasn't until the following year the public demanded free measles clinics . . . and got them.

Rubella Vaccine
Mumps Vaccine

Immunization Policy

The same situation will occur shortly when a live attenuated mumps vaccine becomes available and when a rubella vaccine is released. Advance knowledge of these gives MSMS adequate opportunity to prepare to make the most of these discoveries in increased service to the public . . . *and to keep this service in conformance to professional policies.*

Evaluating Effect on Practice of Anticipated Scientific Breakthroughs

These obvious examples are only indicative of the vast changes which continually will be caused in the practice of medicine by the knowledge explosion in the scientific field. The MSMS, as the leader of the medical profession, has a responsibility to evaluate these anticipated breakthroughs in the light of their effect upon medical services and medical practices.

System for Pretesting Scientific Advances in Practice

Also, an enormous scientific contribution can be made by the establishment of a system for pretesting and evaluating medical scientific progress as the various new things prove out, or fail to do so, in active medical practice.

Related Sciences

Data Processing
Computers

Perhaps even more can be gained if MSMS could apply its members' know-how to the scientific advances being made in other sciences related either to medical science or more particularly to medical practice. Opportunities abound in the field of data processing and the use of computers to apply their services to the prevention of illness, the healing of patients, and the *keeping track* of what has happened, what is happening, and what can happen in a medical world where change is proliferating at unheard-of speed.

Bioengineering
Automation
Chemical Engineering
Biochemistry
Biophysics
Hospital Engineering

Computer engineering is only a more obvious example. The whole field of bioengineering, automation, chemical engineering (particularly in the use of silicones), biochemistry, biophysics—not to mention the emerging discipline of hospital engineering—offers great promise toward improving the service and practice of medicine, which assuredly is one of the MSMS' main responsibilities.

Hospital Cost Accounting
Multimedia Instruction
Core Curriculum

"Science" can also be used when referring to such techniques as hospital cost accounting and multimedia instruction in a core curriculum. Even prepayment mechanisms are subject to "scientific research," as are all forms of communication media. Strangely enough, all of these can

Exploit Science to Increase Efficacy of Medicine

contribute to the efficacy of medicine if they are exploited for that good purpose: Not quite strange after all—if you believe DeForrest's statement that "all science begins and ends with medicine."

Conclusion: MSMS could make a real progress toward advance planning for itself and assist the profession generally if it chose to research the effects on practice of medical and related-medical scientific advances. A very valuable service to the scientific community would be engendered. In addition, the advance planning would permit the profession to serve the public better and at the same time maintain its policies.

Questions

Electronic Revolution

A. What will be the effect of the electronic revolution on patient care? Could complete instrumentation be an important factor in saving lives?

Data Processing

B. What will be the results on patient care of further application of data processing?

Bioengineering

C. What will be the results in treatment arising from bioengineering advances?

Rehabilitation

D. What will be the results in patient care of success in present promise of rehabilitation medicine?

E. What effect in the physical layout of health institutions will be caused by automation?

Automation and Interdependency

F. What effect will automation have upon the interrelationship and interdependency of physicians?

Isotopes

G. Of what value will isotopes be as a tool for basic research into the nature and cause of disease, and what effect is this likely to have on diagnostic practices?

Early Prosthesis

H. What effect will the program of early prosthesis have upon the practice of orthopedics, particularly in amputation of the lower extremities?

Psychotherapeutic Drugs

I. Valuable new developments in the treatment of schizophrenic patients may come about as a result of the synergistic action of psychotherapeutic drug combinations. What effect will this have on the mental health picture?

Mumps Vaccine

J. What will be the probable effect on pediatric care when a live attenuated mumps vaccine is ready for routine use?

Rubella Vaccine

K. What will be the effect on maternal health and child welfare if the vaccine against rubella is the "probable success" predicted?

Artificial Heart

L. How significant will a totally implantable artificial heart be in surgical care?

Hospital Engineering

M. Should MSMS provide consultation on medical practice to assist engineers and architects who are researching the field of hospital construction and operation?

MEDICAL EDUCATION

Discussion

Tradition and Expansion

When physicians hear the words "medical education," their first reaction is to think of a medical school. Michigan has a great medical school tradition, and medical education is expanding in both facilities and students at a rapid rate.

Michigan Association for Regional Medical Programs

It is not necessary to elaborate herein upon the formalized program presently going on, but it should be noted that there is a fine spirit of cooperation among the three schools. Further, the Heart-Cancer-Stroke legislation has resulted in their joining in the Michigan Association for Regional Medical Programs with an initial federal grant of over one million dollars. MSMS is represented in MARMP.

MSMS Relationship to Medical Schools

Concern for Patient

MSMS and the three medical schools highly respect each other, and the spirit of friendly cooperation grows each year. Medical educators are sometimes criticized for failing to impart at the student level the social and economic aspects of medical care which the private practitioners feel to be equally important to the welfare of the patient, the physician, and the public. However, The U-M Medical School and MSMS jointly offer a voluntary series of lectures given by men in private practice to the senior medical students, and Michigan State University College of Human Medicine has a course on medicine in society. More than lip service is being given by those in medical teaching and research activities to the concept that concern for the patient and his pocketbook is a prime function of all physicians.

Medical Practice Patterns

It is becoming increasingly apparent that medical schools will play a greater part than ever before in determining the medical practice patterns of the future. It is equally apparent that, if MSMS is to have an influence upon these patterns, it must work with the schools. MSMS has a great deal to offer them.

Medical Care Team Education

Many persons who are nondoctors are receiving at least part of their training in medical schools.Thus, once again, it must be noted that the medical care team of the future is being decided upon in the medical schools of today.

There is an exceptionally active program in other institutions than medical schools which involves either the teaching of health techniques or the teaching of teachers of health. Medicine's influence and service to these is not great, but the influence of the techniques and concepts taught is of great sociomedical importance.

MSMS might well explore instructional techniques so it can work with educational institutions and others in teaching health.

Michigan is not fulfilling its responsibility in medical education, however:

Michigan "Debtor" State

1. It continues to be a "debtor" state in the education of physicians, and there is an insufficient number of physicians in Michigan.

Student Financial Support

2. The MSMS has no effective system to do enough to assist capable students in their financial problems incurred in obtaining a medical education.

Postgraduate Education

3. MSMS does not require postgraduate and continuing education and perhaps is not providing sufficient motivation to make up for this lack of compulsion.

Training in Social Responsibilities of Doctors

4. The indoctrination of postdoctoral house staff training is not sufficiently permeated with the social roles and responsibilities of doctors. Too often, the specialty training of the resident and intern emphasizes techniques and procedures without developing real concern for the whole patient.

Unfilled Internships and Residencies

5. Nearly fifty per cent of the graduating class of Wayne State University will intern in other states; considerably over fifty per cent from the University of Michigan will do the same. Yet, only 294 of the 621 authorized internships in Michigan will be filled. Fur-

thermore, 30 to 35 per cent of the internships and residencies that are filled in Michigan will be foreign interns and residents. It is apparent that an immediate study should be made of why this is so and what effect it has upon whether U-M and Wayne graduates establish practice in Michigan.

Medical School Teachers

6. Michigan needs to do more—as do all states—in the preparation of medical school teachers. The number of unfilled medical school faculty positions exceeded one thousand in the year 1965-66 and increased in 1966-67 in the nation as a whole.

State Support for Medical Schools

7. States (Michigan included) have abdicated their responsibilities in paying for their medical schools. The federal government in the last 10 years has doubled its percentage of total medical school expenditures (30 per cent to 60 per cent).

Conclusion: A good foundation for cooperation between the medical profession and medical education exists through MSMS. A more active program is needed now.

Questions

Variety of Health Educational Institutions

A. How can the unique and appropriate contribution of a variety of institutions of education and training for health workers be identified, credited, and assisted?

Guidance Counselors

B. How can increased emphasis be given to the education of guidance counselors in the field of medicine and health?

Medical Service Trends and Education Patterns

C. Can methods be developed to provide a continuous overview of medical service trends so that educational patterns can be cut to meet the practical needs of the future?

Multimedia Instruction

D. How can the multimedia approach to instruction be used effectively and efficiently in the continuing education of practicing physicians?

Local Teachers of Medical Extension Courses

E. Is there value in the idea of training doctors in private practice to be teachers who serve the medical school on a part-time basis, carrying to their colleagues instruction in medical school extension courses?

Medical Indigence and Education

F. What will be the effect on teaching when and if medical indigence no longer exists and the "teaching material," which heretofore has consisted of medical indigents, disappears?

Higher Mathematics and Medicine

G. Should the medical school offer courses in higher mathematics and physics—for both the undergraduate and the practicing physician—in order that he might understand computer operation and electronic instrumentation and employ them in his practice?

If it doesn't work in a week, forget it.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, ex-

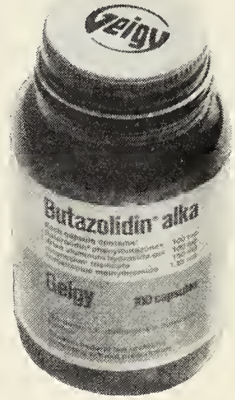
In rheumatoid arthritis, Butazolidin alka needs only a week's trial. If it doesn't work in a week, forget it.

A short trial period may spare patients weeks of discomfort. That's one reason why Butazolidin alka seems a good choice when aspirin fails.

It's not for every patient. Check carefully the Contraindications, Warning, and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

You'll know quickly if it works.
And most of the time, it will.



foliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules or tablets daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules or tablets daily; response is often achieved with 1 or 2 capsules or tablets daily.
6509-V(B)R2
For complete details, please see full prescribing information.

Butazolidin® alka

Capsules: phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

Also available: Butazolidin®, phenylbutazone: Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

BU-5412S

What Massachusetts Medical Journal Says About Osteopathic Schools:

(Editor's Note: The following article, which will be of interest to MSMS members, appeared in the October issue of the Massachusetts Physician *and is reprinted with permission.)*

There was a time when the medical profession looked upon the practice of osteopathy as a cult, but this is universally so no longer. Osteopaths can practice medicine and surgery without restriction in 38 states, including all the New England States, and they have been recognized by federal legislation.

AMA official policy regarding osteopathy has undergone a marked change over the years. A resolution outlining present policy is as follows:

> Voluntary professional association with a Doctor of Osteopathy should not be deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by the American Medical Association.

In addition, individual states are encouraged to develop relationships between practicing MDs and DOs in accordance with this policy.

AT THE JUNE 1967 meeting of the AMA in Atlantic City, another step was taken to bridge the gap between the MDs and the DOs. The House of Delegates voted to authorize the Board of Trustees to begin negotiations directed toward changing osteopathic schools to schools of medicine. In its report to the House, the Board of Trustees said that the issue today no longer is cultism versus science, but one level of medical education and practice as opposed to another and lower level of medical education and practice.

Currently, there are five osteopathic schools from which 400 osteopaths are graduated yearly. The schools are located in Chicago, Des Moines, Kansas City (Mo.), Philadelphia and Kirkeville, Mo., with a total student enrollment of over 1,600. There are approximately 13,000 osteopaths in the United States. Only a minority of the osteopathic physicians who are all in the older age group practice the cultist form of therapy.

DURING 1966, a total of 396 osteopathic graduates were examined by U.S. state licensing boards; 65 failed and 331 were passed. The states accepting the largest number by examination were Missouri with 232; Ohio, 82; and New York, 10.

During the years 1960-1966, Missouri approved by examination 1,527 osteopaths; Ohio, 451; Illinois, 242; New York, 152; and Texas, 19. The number of those in other states during this period varied from 15 to 1. Massachusetts added 22 during this period, 2 by examination and 20 by reciprocity and endorsement (*JAMA*, June 1967).

Osteopathy is not a great problem in New England. There are 27 osteopaths in New Hampshire, 39 in Vermont, 64 in Connecticut, 82 in Rhode Island, 221 in Maine, and 303 in Massachusetts. (*Boston Globe*, July 23, 1967) During 1966, Maine added 10 additional osteopaths to their lists: Rhode Island, 3; and Connecticut, 1; in the other New England States there was none.

IT IS INEVITABLE that there will be considerable resistance on the part of some members of the osteopathic organization to the loss of their identity. In fact, the president of the American Osteopathic Association has been quoted as saying that the AMA move is a political attempt to control all of American medicine.

The shortage of MDs in the U.S. continues despite the 1,500 foreign medical school graduates who come here annually. The conversion of the osteopathic schools to the level of education of U.S. medical schools would, therefore, be helpful to our overworked physicians and to the people of the United States.

MSU Grant from Kellogg Aids Nursing Education

A Kellogg Foundation grant of $451,200 to provide continuing education for Michigan nurses and to strengthen the faculty of the School of Nursing at Michigan State University over the next five years has been accepted by the MSU Board of Trustees.

Gwen MacDonald, director of the School of Nursing, said the continuing education program will help nurses advance their knowledge of organization and management, clinical nursing and the physical and behavioral sciences which underlie nursing practice.

The faculty development portion of the grant will enable faculty members to study at other collegiate nursing schools and medical centers, to bring in consultants and visiting professors, to provide for appointments in the school faculty from related areas such as nutrition, social work and pharmacology, to develop graduates of the school with a potential for teaching, and to provide travel to professional meetings and workshops.

About 220 MSU students are now taking nursing education courses, and an equal number of other students, mostly freshmen, have indicated nursing as a preference for study.

MSU plans to expand its nursing enrollment as soon as the projected Life Sciences Building (which will include quarters for the School of Nursing) can be built.

MICHIGAN MEDICINE
DEADLINE FOR THIS BREAKING NEWS WAS NOVEMBER 21, 1967

Legislative Leaders Urge Physicians Take Even Greater Interest in Government

"The work you do now will be reflected in the composition and productiveness of the next Congress."

So declared U.S. Rep. Marvin Esch, Ann Arbor, during his comments at the recent MDPAC Political Action Workshop.

The importance of the workshop was stressed time and time again by the speakers. For example, State Rep. William Ryan, in part, said he sees the workshop as the turning point for more dialogue between doctors and legislators for the mutual benefit of each and the general public.

CONGRESSMAN ESCH told the 75 doctors, wives and friends, "that as our society becomes more complex, the attempts to standardize, etc., take away individualities of local government and local people. The professions must work to maintain the one-to-one human factor in our nation. The focal point in America is the human factor."

The workshop moved smoothly, led by MDPAC Chairman Vernon V. Bass, M.D., Saginaw, and Workshop Chairman Donato Sarapo, M.D., Adrian.

Top leaders from the Michigan Legislature spoke highly of the medical legislation and presentations, and urged a continuing heightening of interest in government by physicians.

MICHIGAN LEGISLATORS who spoke included State Senators Gilbert Bursley, Ann Arbor; George Fitzgerald, Detroit; Emil Lockwood, St. Louis; and Roger Craig, Dearborn; and State Representatives Ryan, James Heinz, Battle Creek; Ray Smit, Ann Arbor.

Republican party spokesmen included William McLaughlin and Jerry Roe and the Democratic party spokesmen were Secretary of State James Hare and H. James Starr.

James Rosevear, Minneapolis, AMPAC fiield representative, participated on a panel.

"Dial a Doctor" In Bay County

To assist newcomers in finding medical service, the Bay County Medical Society has set up a special referral telephone number.

When a newcomer, who has not previously been treated by an area physician, wants medical attention he simply dials 892-1991 between the hours of 8:00 a.m. and 4:00 p.m., Monday through Friday.

The caller will be given the names of three physicians, when possible, to choose from.

The service is an informal agreement among participating physicians to accept new patients, said F. J. Chapin, M.D., president of the society.

MICHIGAN
STATE
MEDICAL
SOCIETY

MSMS MEMBERSHIP PIN IS NOW AVAILABLE . . .

The MSMS Membership Pin is featured on the cover of the new 1967-68 Membership Directory. To obtain your pin, send your order to MSMS, 120 West Saginaw, East Lansing 48823, with a check for $3.00 made payable to the Michigan State Medical Society.

The relationships between the Michigan Association for Regional Medical Programs (MARMP) and MSMS were explored recently by seven leaders of the two organizations. In photo at left, Don Marshall, M.D., standing at right, vice-chairman of MARMP, discusses a report with Richard Pomeroy, M.D., seated left, chairman, MSMS Committee on Rehabilitation; Max Dodds, M.D., standing left, chairman, MSMS Committee on Cancer, and Harry A. Towsley, M.D., seated right, chairman, MSMS Committee on Postgraduate Medical Education. In the photo at the right, three doctors review some MARMP minutes; they are, left to right, D. Bonta Hiscoe, M.D., alternate MSMS representative to MARMP; Albert E. Heustis, M.D., now the executive director of MARMP, and Lawrence Birch, M.D., who represented the chairman of the Committee on Cardiac Disease.

MSMS Leaders Get MARMP Insights

MSMS was host on October 18 to the first of several informational meetings between MARMP (Michigan Association for Regional Medical Programs) and selected MSMS committee chairmen.

Don Marshall, MD, MSMS representative to MARMP, was chairman of this event.

The MSMS Council had approved a recommendation from a MSMS committee "that the State Society organize a meeting of scientific committee chairmen and others interested in heart, cancer and stroke in order to allow these persons to discuss the part to be taken by MSMS and the many plans now being made."

The purpose of this initial meeting was to emphasize the definite need for conveying information from MARMP to MSMS committees and also to MARMP from the individual MSMS committees. MARMP spokesmen stressed their desire to receive ideas, comments and suggestions from MSMS committee chairmen.

An important part of the meeting was the question of whether MSMS should participate in MARMP as a Society through several committees, or only through its physician membership on voluntary agencies, hospital staffs and county societies.

It was made emphatically clear that the medical profession and the Society can serve as a central core, a catalyst, and a balance wheel in guiding the progress of the many projects anticipated in this increasingly important medical program.

Doctor Marshall said, "In the final analysis the problem is to determine how MARMP can properly, effectively and efficiently work everywhere in the state to best improve the ability of the health team and the care of the patient."

MSMS is a participating member of MARMP, which received an initial planning grant in June of $1,285,155 for a central staff and for projects proposed by the three medical schools and the state health department.

OFFER MICHIGAN FILM ON LEGISLATIVE PROCESS

"The People of Michigan Enact," a half-hour color film providing a glimpse of the law-making process in Michigan, is now available to schools and other interested organizations.

Filmed mainly at the Capitol in Lansing, the movie shows the House and Senate chambers, committee rooms, and the legislators at work.

Copies may be obtained from the Film Library, Michigan State Library, Department of Education, Lansing. There is no charge for the film, but users are to pay the film's return postage to Lansing.

New Medicare Payment System Tested at MHS

A time and dollar saving system for handling Medicare hospital payments, developed by Michigan Hospital Service and now being tested in Detroit, is being watched for possible adoption nationally.

"If this pilot program is successful, indications are that these improved procedures and other modifications will be adopted nationally," says Wm. S. McNary, Blue Cross president.

The new streamlined system of handling a Medicare hospital case — from the time a beneficiary enters a hospital until the hospital is paid and all records are properly updated — was suggested early this year by Michigan Blue Cross Chief Accountant Charles F. Stallkamp during a meeting in Chicago with SSA personnel. Mr. Stallkamp proposed to enter directly on magnetic tape the coded hospital bill information necessary to make payments to Michigan hospitals and to supply on tape the data required by the SSA computer complex in Baltimore, Maryland.

Under the original method, each hospital bill, after being used by Michigan Blue Cross for billing and statistical purposes, was sent to Baltimore, where SSA systems personnel punched between five and seven cards for government computer requirements.

Instead of bulk mailing all hospital bills to Baltimore, only the daily tape and a sample of hospital bills now are dispatched from Detroit to Baltimore.

Conference Slated On Epidemiology

The program is set for the Third Conference on Epidemiology presented by the Bureau of Community Health, State Department of Public Health, December 13, 14 and 15, at the Inn America, East Lansing.

Buchanan Physician Serves in Vietnam

J. Colin Elliott, M.D., Buchanan, left Michigan November 3 for a two-month tour of duty in Vietnám under the AMA "Volunteer Physicians for Vietnam" program.

Before leaving, Doctor Elliott said that he is "looking forward to seeing people with diseases, not just disabilities. The doctor today is almost supposed to have a lie detector test in his little black bag to tell whether or not a person is really disabled. I'm tired of all the forms and formality a doctor has to go through before he can really see a patient."

Under the AMA program, a physician works for two months in a provincial hospital caring for South Vietnamese civilians. In return he receives transportation, insurance, living quarters and ten dollars a day for expenses. Doctor Elliott is the ninth Michigan physician to serve under the program.

MSMS Initiates New Medi-Label Push

BY HERB MEHLER
OF THE MSMS STAFF

With re-dedicated purpose, the MSMS Committee on Highway Injury has started an extensive educational campaign to again promote the continued use of the Medi-Label stickers on driver's licenses.

Distribution also has been authorized to responsible lay organizations. Although the method of distribution is left entirely to the organization there is one important and necessary requirement. Information will be clear and concise that, in order that proper and current medical data appearing on the sticker is authentic and up-to-date, medical information can only be appended by the patient's physician.

The stickers, designed by MSMS and subsequently approved by the Michigan Secretary of State, carry the Society's name, the words "medical data," and sufficient blank space for comments or medical informatitn which the physician deems advisable.

It is expected that the stickers will become an integral part of the license and will tend to increase the number of persons that should carry such vital medical emergency data. The new license, in addition to carrying a color photograph, is encased in plastic for durability. When designed, the reverse side of the license was left blank to accommodate the Medi-Label.

Although a record of tetanus immunization would be invaluable in cases where accident victims suffered open wounds, other vital data might be, in the opinion of the physicians, equally pertinent.

Physicians wishing a supply of these labels may write to:

Project Medi-Labels
Michigan State Medical Society
120 W. Saginaw Street
East Lansing, Michigan 48823

Medical Career Paperback Now Available Again

The growing popularity of "Horizons Unlimited," an AMA paperback which describes the variety of medical careers, is witnessed by a recent 25,000 shipment to MSMS headquarters.

Michigan has the distinction of being the first state to develop a localized edition of this book. By means of a special insert a person can find listed all the Michigan colleges, universities, hospitals, and institutes which train medical personnel.

The book is widely used by schools and guidance counselors throughout the state, report officials of MSMS and the Michigan Health Council, joint-purchasers of the 25,000 additional books.

This career effort is supported by the MSMS Public Relations Committee.

INTERNIST ELECT; HEAR SADUSK

The Michigan Society of Internal Medicine meeting recently in Ann Arbor elected Arthur W. Strom, M.D., of Hillsdale, as president-elect and John Milliken, M.D., of Traverse City, as reelected Secretary-Treasurer.

Installed as president was John R. Caldwell, M.D., of Detroit. He succeeds John B. Bryan, M.D., of Royal Oak.

Featured speaker at the meeting, held in conjunction with the Michigan Regional Meeting of the American College of Physicians, was Joseph F. Sadusk, Jr., M.D., Vice President in Charge of Medical Affairs, Parke Davis & Company. His topic was: "This Matter of Prescribing Drugs by Generic Terminology."

Harold C. Mack, M.D., right, WSU professor of gynecology and obstetrics, confers at the Symposium on Prenatal Life with Donald H. Barron, M.D., speaker from Yale School of Medicine.

Prenatal Life Seminar Draws 250 Physicians

A symposium on Prenatal Life, November 1 and 2, at the Rackham Memorial Building in Detroit, was attended by over 250 physicians, residents, and interns.

Sponsored jointly by the departments of gynecology and obstetrics at Wayne State University and Harper Hospital, the symposium brought to Detroit authorities from throughout the U.S., as well as from Uruguay, Switzerland, and Australia.

MIDLAND PHYSICIAN ON MERCY TRIP

Sidney Smock, M.D., a Midland Hospital anesthesiologist, is spending the month of November — his vacation time — training doctors and nurses in contemporary anesthetics at Brokenshire Memorial Hospital on the island of Mindanao, Philippines.

"Mere things are no answer," Doctor Smock said in discussing the philosophy behind his trip. "Giving of largess simply makes one an 'ugly American' and there are no lasting benefits either for the giver or the recipient. Education comes first and knowledge of how to use progress. After that self help is almost certain and material assistance is both more valuable and more appreciated."

Muskegon Society Sponsors Weekly TV Series

The Muskegon County Medical Society is currently sponsoring a weekly television show on health matters over station WMKG-TV.

"We think this show carries an impact and is one of the most effective means we've used to reach people," says Warren White, M.D., president of Muskegon County Medical Society. "We're taking health messages right to people's homes."

The show is broadcast each Thursday evening at 8:00 PM and has been running since September 21 with topics such as "Planned Parenthood," "Your Life's Blood," and "Motherhood Expected." In December three shows are planned dealing with "Air, Land, and Water Pollution."

Organizing the series is Leland Holly, II, M.D., chairman of the Public Health Committee of the Muskegon County Medical Society.

What can a county medical society do to set up such a series in their own area? "First you need a good organizer like Doctor Holly," says Doctor White. "Then you approach the director of the station with a definite set of speakers and topics. Also we've found it helpful to include lay people, who have interest and knowledge about a particular topic, on the show."

To Continue Study Of University Research

A legislative committee study of the use of grants and research funds by state colleges and universities has proved such a formidable task that the reporting deadline may be extended. Rep. James F. Smith (R-Davison) has asked the Legislature to extend the deadline of the study, scheduled to end before the 1968 Legislature convenes, until December 31, 1968.

viewpoints

Urges League Focus On Social Problems

BY BROOKER L. MASTERS, M.D., CHAIRMAN
MSMS PUBLICATION COMMITTEE

In mid-November the Michigan Welfare League held its Annual Conference in Lansing's Civic Center. Throughout a program billed "Blueprint for Action" the League examined the many facets of irritation which may have significantly contributed to this Summer's civil strife throughout Michigan.

The League is to be commended for focusing attention on a massive problem area which is directly related to MWL's primary purpose — the welfare aspects of families and of communities. We think the League, which from time to time seems to have had its purposes confused, is on the right track.

WITH THE ADVENT of the '60's, this League was holding forth on the theme that "human services," — and in this they included mental health, medicine, child health, health of the aged and other aspects of health — were *all* the proper concern of the Michigan Welfare League. This sort of approach diffused its effort. As a matter of fact, in a switch from the League's basic orientation (it developed out of the Conference of Social Work) an intense interest in *health* matters culminated in a suggestion that the organization's name be officially changed to the Michigan Health and Welfare League!

The Michigan State Medical Society, at that point, suggested that MWL devote its energies to the sorts of problems which it was founded to attack.

We applaud the Michigan Welfare League for its apparent new direction in pointing up the distressing *social* problems of our time. The League can do much to appraise the impact of technological change, economic growth, population explosion, employment trends and the like upon Michigan. Hopefully, its better-late-than-never concentration on these problems may bring some answers which will deter another "Summer of protest."

In late 1963 the League recommended that, to comply with the requirements of the new State Constitution, state agencies be consolidated and regrouped into a strengthened "Rehabilitation and Assistance Department," to include welfare, corrections and other services and a strong state health department including mental health and crippled children functions.

THIS RECOMMENDATION retains its basic merit, and could well be reviewed and heeded by those who, in 1967, speak of merging Michigan's splendid Department of Public Health with the Department of Social Services so as to presumably reduce "overlapping and duplication" of functions.

The League *should* address itself to such social problems as disproportionate unemployment, inadequate housing, juvenile delinquency and urban development, working with Michigan's Department of Social Services and other appropriate agencies.

MICHIGAN'S HEALTH professionals, working with a strong Department of Public Health, can contribute much to the total effort by continuing to identify and solve problems in *their* field of expertise.

In this context physicians *can*, and *should*, work shoulder-to-shoulder to build a better Michigan.

Vietnamese Need You

BY ROBERT J. MASON, M.D., CHAIRMAN
THE MSMS COUNCIL

There are 1,000 native South Vietnamese doctors. About 650 of these physicians are now working with the military. This leaves 350 physicians to care for 15 million South Vietnamese civilians.

To help meet the great medical needs of the South Vietnamese civilian population, the AMA is administering a program which so far has sent 320 American physicians to work in Vietnam for two-month periods.

Called "Volunteer Physicians for Vietnam," the program is a non-political, direct person-to-person helping program designed to aid people who are afflicted not only with a host of oriental diseases but also with scores of war casualties among innocent men, women, and children.

Under the program an Amerinan physician works for 60 days in one of the 21 provincial hospitals in Vietnam. He gets transportation to Vietnam, housing, insurance, and $10 a day for living expenses. In return he gives 60 days of backbreaking work which uses every skill he has developed as a physician.

The AMA program will need 300 volunteers in 1968.

THOSE ARE THE FACTS.

I would like each Michigan physician to look at the immense medical need in Vietnam as a personal challenge, calling him to say either yes or no to a request for 60 days of his working time.

It is a hard request. The man who goes to Vietnam under this program leaves his wife and family behind, goes to a strange place, among strange people, and loses the money he would ordinarily be making in his practice back home. And finally, when he goes to bed each night he will most likely be exhausted.

Why should any man do such a foolish thing?

It is somewhat ludicrous to try to convince someone to do something heroic or to give reasons for it.

All I can say is that the men, women, and children of South Vietnam need you. Their problems are desperate. They won't come to you with a cold or a headache, but with a gaping wound or a TB case in its last stages.

At the September Annual Meeting, the MSMS House of Delegates, voted that the several Michigan physicians who "at great personal sacrifice have volunteered their services to the civilians of South Vietnam . . . be given highest praise and commendation for their outstanding work in this valuable portion of the international health activity of the medical profession in Michigan."

IN THE WORDS of Robert F. Baugh, M.D., one of the Michigan physicians who has served in the AMA program, "You get a sense of being overwhelmed by the tremendous medical need when you are over there. Vietnam could absorb as many doctors as we could send."

Your reward if you choose to help meet that need? A simple one: The feeling you get, and what someone feels toward you, when you save his life.

For information contact: AMA Department of International Health, 535 North Dearborn Street, Chicago, Illinois 60610.

But We Must Not Relax

BY GEORGE H. LOWREY, M.D.
SCIENTIFIC EDITOR

As the winter winds blow and we approach the peak of the season for measles (Rubeola), it is worthwhile to take a look at the effectiveness of measles vaccine and the results of the recent anti-measles campaign.

It is unfortunate that many people consider Rubeola a necessary nuisance that all children must experience. Approximately 90% of American adults have had measles and probably because of this the most serious aspects of the disease may go unrecognized.

In 1966, which was a relatively mild year for the disease, nearly 250 children died as a direct result of measles.

Equally tragic because of the permanent disabilities, is the relatively common occurence of measles encephalitis. The incidence of this complication appears to vary with different epidemics but probably occurs at least as often as 1 in every 10,000 cases. Approximately 10% of these children die of this complication and more than 65% will survive with some degree of mental retardation, deafness or blindness. The peak incidence of this disease is seen usually in February and March.

THE REPORTED INCIDENCE of measles for the first half of 1967 was the lowest ever recorded in the United States. In the State of Michigan, the total number of recorded cases was only 814. This is in comparison to our most recent severe epidemic year of 1963, when there were 48,752 cases. Thus, it can be seen that the campaign for immunization against measles has been most effective both on a national and state level. We are well on the way to eradicating another serious disease.

Although some minor reactions have occurred due to the use of the live vaccine for immunization, the incidence of them is low and they are usually well tolerated. Serious reactions are practically nil. There seems to be little reason now for not including this vaccine as a routine procedure in our immunization program to be administered in the second half of the first year of life.

Evidence now available would indicate that such an immunization procedure probably conveys immunity for life.

The universal acceptance of measles vaccine is strongly recommended and it should be incorporated into our other procedures for the adequate immunization of our population against the contagious diseases. The Michigan Department of Public Health and the physicians of the State are to be congratulated for a job well done.

Mandatory Fluoridation

BY H. DEAN MILLARD, D.D.S., EDITOR
MICHIGAN STATE DENTAL
ASSOCIATION JOURNAL

The recent efforts of Albert E. Heustis, M.D., director of the Michigan Department of Health, to effect a rule requiring fluoridation of public

Continued on 1596

DUAL PROBLEM IN PEPTIC ULCER

Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

THIS IS WHY MYLANTA® PROVIDES:

the two most widely used antacids—magnesium and aluminum hydroxides—to help secure rapid acid neutralization with little chance of laxation or constipation;

PLUS

the defoaming action of simethicone—to help relieve the painful gas symptoms which often accompany peptic ulcer.

Mylanta®

antacid therapy plus an added benefit

nonfatiguing flavor/smooth pleasant texture; both assure patient cooperation during long-term therapy.

Stuart Division of / ATLAS CHEMICAL INDUSTRIES, INC. / Pasadena, Calif.

water supplies serving communities of more than 1,000 persons currently requires only final approval. Michigan's citizens will benefit from the results of mandatory fluoridation beyond measure.

Effectiveness, safety and legality of fluoridation have been thoroughly tested and proven. The reduction in human suffering from odontogenic pain and infection, among other ills attributable to dental decay, are direct benefits for the people of Michigan. Saving money is always appealing and mandatory fluoridation will ultimately result in less private expenditure for dental care and less money needed for tax supported programs of dental care.

At the end of 1966, Michigan ranked 32 in the nation with respect to the percentage of its citizens drinking fluoridated water. About one-third of the population benefited. Fluoridation in Detroit advanced Michigan's national position significantly. The current move for mandatory fluoridation will benefit nearly all of Michigan's city dwellers as well as many persons living in small communities, and will place Michigan among the leading states of the nation in population served by fluoridated water.

Dr. Heustis, Dr. C. V. Tossy and others in the Michigan Department of Health and leaders from organized dentistry in Michigan are to be congratulated for their courage and foresight in seeking the issuance of a rule for mandatory fluoridation. As a result of their action, Michigan will stand among the first five or six states to enact similar measures requiring statewide fluoridation.

Nationwide, fluoridation, a goal for the future, one step nearer.

Free Choice of What?

BY R. C. DERBYSHIRE, M.D., EDITOR
FEDERATION BULLETIN,
SANTE FE, NEW MEXICO

We are continually puzzled by the many instances which we see of perversion of the meaning of "free choice of physician" upon which the American Medical Association has placed so much emphasis in recent years. For example, most of the crank calls and letters we receive after revocation of a physician's license, no matter how heinous his crimes, emphasize that the board had no right to take such an action because it interferes with the "free choice" of the patient.

SINCE THE BEGINNING of time charlatans have preyed upon a gullible public and even in these enlightened days of universal education they continue to do so. Some people contend that certain quacks if they do no physical harm to people, might help them when medicine has nothing to offer. Moreover, they argue that the victim should have complete freedom to consult whichever quack he chooses.

Unrecognized is the duty of the authorities to protect people against their own impulses in this matter just as it is the function of the public health officers to prevent them from drinking contaminated water.

More complicated is the extension of the doctrine of "free choice" to certain cultists who, through legislative channels, have attained a certain veneer of learning and respectability and who now almost universally take advantage of the false label, "doctor." We refer, of course, to the chiropractors.

THE EFFORTS OF THE chiropractors to broaden the scope of their activities continue and their latest strategy is to try to obtain approval for the treatment of patients under the Medicare program. This and all future attempts must be vigorously opposed by the medical profession as was emphasized by Doctor Sabatier, chairman of the AMA Committee on Quackery in his letter to the editor in the August *Bulletin*.

Recently Doyle Taylor, Director of the AMA Department of Investigation, kindly sent us a packet of information about chiropractic with a letter asking whether or not we thought this deserved wider dissemination to boards of medical examiners and state medical societies. Our answer was an emphatic "yes" as it contains a wealth of factual material, some of which would make amusing reading if it weren't potentially so tragic.

For example, the following treatment of heart disease is set forth in a text book published in 1947 and still used in chiropractic schools. "Careful circular finger tip manipulation over the precordium results in a definite relaxation of the coronary arteries and has been advocated in the treatment of angina and other conditions."

Let us redefine the doctrine of "free choice" to the people who are best able to halt the march of cultism, the legislators.

Meanwhile the AMA has already demonstrated its willingness to help state societies fight their legislative battles to protect the public against too much "free choice."

(Editor's Note—The above editorial was reprinted with permission of the editor from the September, 1967 issue of the Bulletin of the Federation of State Medical Boards of the United States.)

...meeting the challenge
of changing needs

Blue Shield's new Variable Fee and Extended Benefits program represents a progressive idea in prepayment plans — demonstrating the superiority of the voluntary system, meeting new problems in medical costs head on.

Remember, as a Blue Shield participating physician, you're serving the best interests of your patients *and* yourself.

MICHIGAN BLUE SHIELD

A booklet describing this program in complete detail has been mailed to all physicians in Michigan. If you did not receive it, or if you have any questions, write Michigan Blue Shield, or contact your local Professional Relations representative.

Evans to Address Maternal Welfare Conclave Banquet

Jack W. Thompson, M.D., Flint, Chairman for the Seventh Annual Michigan Conference on Maternal and Perinatal Welfare, has announced that the banquet speaker for the event will be T. N. Evans, M.D., Professor and Chairman of the Department of Gynecology-Obstetrics at the Wayne State University School of Medicine. Doctor Evans, who is well known throughout the state, will speak on "Prenatal Disasters."

The Conference will take place on March 26 and 27, 1968, at the Pick-Durant Hotel in Flint. The afternoon of talks, which begins Tuesday, March 26, at 1:30 p.m. will be concluded by the banquet and Doctor Evans' speech. Addresses will begin again at 9:00 Wednesday morning and continue until adjournment of the conference at noon.

This meeting, which is held every Spring in cooperation with the Clara Elizabeth Fund of Flint, is open to doctors, nurses, social workers and others interested in maternal welfare.

MSU MEDICAL STUDENTS LEARN ABOUT MSMS

The second-year medical students at Michigan State University were guests of MSMS at a dinner-meeting on November 15 at Society headquarters.

Kenneth A. Johnson, M.D., MSMS Secretary, represented the Society and spoke of the necessity for and need of an association of physicians. He stressed that medical societies of today are updated on what is going on and that the Society can and does serve as both a protector and as an advisor to the public and the physician. He clearly emphasized that such services are particularly needed in the present and future eras due to the complexity of the relationships between groups, individuals, doctors, vendors, third parties, etc.

Stewart Kerr, MSMS Legal Counsel, then briefed the students on the many technical and complex problems facing the medical practitioner today and cited different areas where the law and medicine come into juxtaposition.

Herbert Mehler, MSMS Staff, served as secretary at the meeting and also participated in the informative and interesting question and answer period that followed.

This gathering resulted from an inquiry of the availability of someone from the Society to address the students on the legal aspects of the practice of medicine. It was then proposed that it might be helpful to these students to receive information on other important subjects and responsibilities they encounter as practitioners.

The meeting is a continuation of similar programs previously held during the school year for medical students of the University of Michigan and Wayne State University.

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Dec. 4-5—Institute for Guidance Councilors, Michigan Education Association Conference Center, St. Mary's Lake, Battle Creek

Dec. 6-7—15th Annual Symposium on Trauma, Wayne County Medical Society Headquarters, Detroit

Dec. 6-7—Conference for Head Nurses, Kellogg Center, Michigan State University, East Lansing

Dec. 12-14—Administration in Environmental Health, Michigan Department of Public Health, Union Building, Michigan State University, East Lansing

Dec. 13—The Council, MSMS Headquarters, East Lansing

Jan. 19-20—16th Annual Symposium on Blood, McGregor Memorial Conference Center, Detroit

Jan. 24—Seventh Annual Thyroid Workshop, Wayne County Medical Society Headquarters, Detroit

Jan. 24—Seventh Annual Workshop of Wayne State University School of Medicine, Wayne State University Medical School, Detroit

Mar. 26-27—Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

Apr. 22-25—Joint meeting of the American Association of Physical Anthropologists and the Stciety of Human Biology, Detroit

Apr. 23-28—17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

May 1-8—Mental Health Week

May 8-10—Michigan Public Health Association, Inc., Annual Conference, Jack Tar Hotel, Lansing.

May 10-11—Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 18—Kresge Eye Institute Clinic Day, Detroit

May 18-19—Pediatric Clinic Days

Nov. 11-15—American Public Health Association Annual Conference, Detroit

Michigan Magazine Index Lists Articles from "Michigan Medicine"

References to articles published in *Michigan Medicine* frequently appear in *Michigan Magazine Index,* a bibliography compiled by the State Library of the Michigan Department of Education.

Among those articles chosen to be listed in the state publication for January-March 1967 were the following, alphabetized here by author:

Ralph W. Daniel, Michigan Department of Public Health, "Urges More Alcoholism Programs in Michigan's General Hospitals, January 1967.

John R. G. Gosling, M.D., Ann Arbor, "A Medical School at the University of Michigan — A View after 150 Years," February 1967.

W. N. Hubbard, Jr., M.D., Ann Arbor, "The Sesquicentennial of the University of Michigan's Role in Health," February 1967.

Jose' J. Llinas, M.D., Lansing, "Early Strategies in the Treatment of the Alcoholic," November 1966.

Elliot D. Luby, M.D., Detroit, "On the Nature of Memory," November 1966.

Paul R. Patterson, M.D., "Sex Education of the Adolescent — How, Where, When," November 1966.

C. Allen Payne, M.D., Grand Rapids, "Preliminary Analysis of Medicare," December 1966.

Theresa Phelps, R.N., Brighton, and Muriel Pearse, R.N., Detroit, "New Directions in Nursing Education," March 1967.

Lee B. Stevenson, M.D., Detroit, "Maternal Death and Abortion — Michigan 1955-1964," March 1967.

Deadline Nears for Change In Medicare B Premium

December 31 will be the deadline that the Secretary of Health, Education and Welfare must meet if the present $3 monthly premium for Part B coverage of the Medicare programs to be increased. The AMA has reported that "the federal government is planning on increasing the monthly medical insurance rate for physicians' services for 1968 and for 1969."

President Johnson on September 30, 1967 signed into law PL 90-97 (HR 13026) which extended the deadline from October 1 to December 31.

The purpose of the extension is to enable the HEW Secretary to include in his cost estimates any medical insurance benefits that may be added by HR 12090, the Social Security Amendments of 1967. As a result of the extension, the new premium will be effective from April 1, 1968 to December 31, 1969; and the present $3 premium will continue at least until April.

The deadline has been extended by PL 90-87 also for the first general enrollment period from December 31, 1967 to March 31, 1968. This extension will enable eligible persons to study any new premium and benefits before they decide whether or not to sign up. Anyone already enrolled has until April 1, 1968 to drop out if he wishes.

The monthly premium is paid by persons 65 and older who elected to get benefits under Part B of the Medicare program providing physician services.

John W. Gardner, Secretary of Health, Education and Welfare disclosed a possible increase from $3 to $4 in a letter to Sen. John J. Williams, Del., ranking GOP member of the Senate Finance Committee.

HEW Secretary Gardner wrote, "I would promulgate a rate of $3.80 for the two-year period of 1968 and 1969, 25 cents of the increase being based upon our evaluation of the extent to which we believe the premium rate was below the actual cost for 1966-67 and 55 cents being the estimated additional cost to be expected from an estimated increase in utilization and in physicians' fees."

Center for Research in Reproductive Biology Department of Obstetrics and Gynecology
University of Michigan Medical Center
Ann Arbor, Michigan

HYDATIDIFORM MOLE OR CHORIOCARCINOMA

Our current research into the etiology and treatment of molar disease urgently requires FRESH TISSUE. Because of the low incidence of this disease we need to solicit help from our colleagues. Should a case come to your attention (before chemotherapy) we would be most appreciative if you would call us to come out and get the necessary material.

We need:—(1) 10-15 ml clotted blood
(2) A few grams of STERILE TISSUE.

Thank you in anticipation.

S. J. Behrman, M.D.
Professor of Obstetrics and Gynecology
Telephone: 764-8124
or
Zeev Koren, M.D.
Assistant Professor of Obstetrics and Gynecology
Telephone: 764-7109

Branch-Calhoun Council Helps Coordinate Health Planning

The decision some months ago to develop a subregional planning group for Branch-Calhoun area health concerns has now matured into a full-fledged organization with elected officers and executives, ways and means, and programs coordinating committees.

Called the Branch-Calhoun Area Health Planning Council, the organization has some features which make it unique in the Michigan scene, according to Edwin Marsh, Director of the Health Planning Council of Michigan. The Council is founded on the solid base of a constituent assembly involving over 100 health oriented organizations in the Branch-Calhoun area.

"I know of no other health planning group which is so all-comprehensive at the base," declared Mr. Marsh. "These organizations met and elected the Council and executive officers of the Council."

"Another unique feature," Mr. Marsh commented, "is that the by-laws of the organization were written when the Federal Comprehensive Health Planning Act was passed. The Branch-Calhoun organization is the first in the state to put the elements of this Act into its structure."

Area physicians are closely involved in the Council. Robert M. Leitch, MD, from Branch County, is first vice president of the Council, and thereby president elect. George T. Kelleher, MD, of Battle Creek, led the organizing committee as chairman and is presently on the Executive Committee.

The swift movement of the Council, since its inception last spring, has resulted in an unusual honor for Doctor Kelleher, according to Edwin Marsh: "He had the unusual honor of being elected past president at the organization's first election."

M/M REPRINTS HELP LURE AUXILIARY MEMBERS

Michigan Medicine has furnished 400 copies of an editorial to the Woman's Auxiliary to help the Organization and Membership Committee recruit more members. Mrs. Earl E. Weston, State Auxiliary president-elect, is chairman of the Committee and requested the reprints.

The editorial, "More Auxiliary Members Are Needed in Michigan" was written by W. G. Gamble, Jr., M.D., Editor of the Bay-Arenac-Iosco County Medical Society Bulletin, and appeared in the October issue.

MULTIPHASIC SCREENING PROGRAM COMPLETED IN SOUTHWESTERN COUNTIES

Almost 13,000 people have passed through a multiphasic Screening Program sponsored by the state and local health departments and the county medical societies in three southwestern Michigan counties.

"The main intent of the program," according to John T. Manning, M.D., a Berrien County Medical Society representative who has been involved mainly in screening electrocardiogram results, "has been to see if we could detect previously undiagnosed disease."

ALTHOUGH THE RESULTS are still being computed in Lansing, it is clear that the screening will reveal health problems in people who do not ordinarily have physical examinations.

The screening took place in three vans which moved together in Berrien, Cass and Van Buren counties. Public announcement was made that they would be available. Then people called in to the health department to make an appointment. A letter was then sent to the person telling him what was to be done.

Enclosed in the letter was a detailed questionnaire containing about 100 items. Then the person went for the screening with the questionnaire already completed.

The testing process involved measurement of height, weight, blood pressure, hearing, and vision. An electrocardiogram reading was taken. A blood analysis was made, checking cholesterol, hemoglobin, creatinine, sugar, and uric acid. A urinalysis was also made and a check X-Ray taken.

If all is normal, the patient is informed. On borderline cases a report is sent to the person's physician for judgement on the necessity of follow up. When there is a definite abnormality a detailed report goes out ahead of time to the physician and then a letter is sent to the patient, thereby making the physician fully informed when the patient comes to him.

The Southwestern Michigan area was the third to have been visited in the past year by the screening vans. Previously they had been in Dearborn and Sanilac county. Screening locations for the winter months are presently being developed.

Coordinator of the program, Patrick Devlin, a public health field representative, praised the County Medical Societies for their "wonderful cooperation" in bringing the screening tests to thousands of people.

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4 fl. oz.
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"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin *plus* belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation.

For acute, non-specific diarrheas
Donnagel® -PG (Donnagel with paregoric equivalent).
Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children.
See product literature before prescribing.

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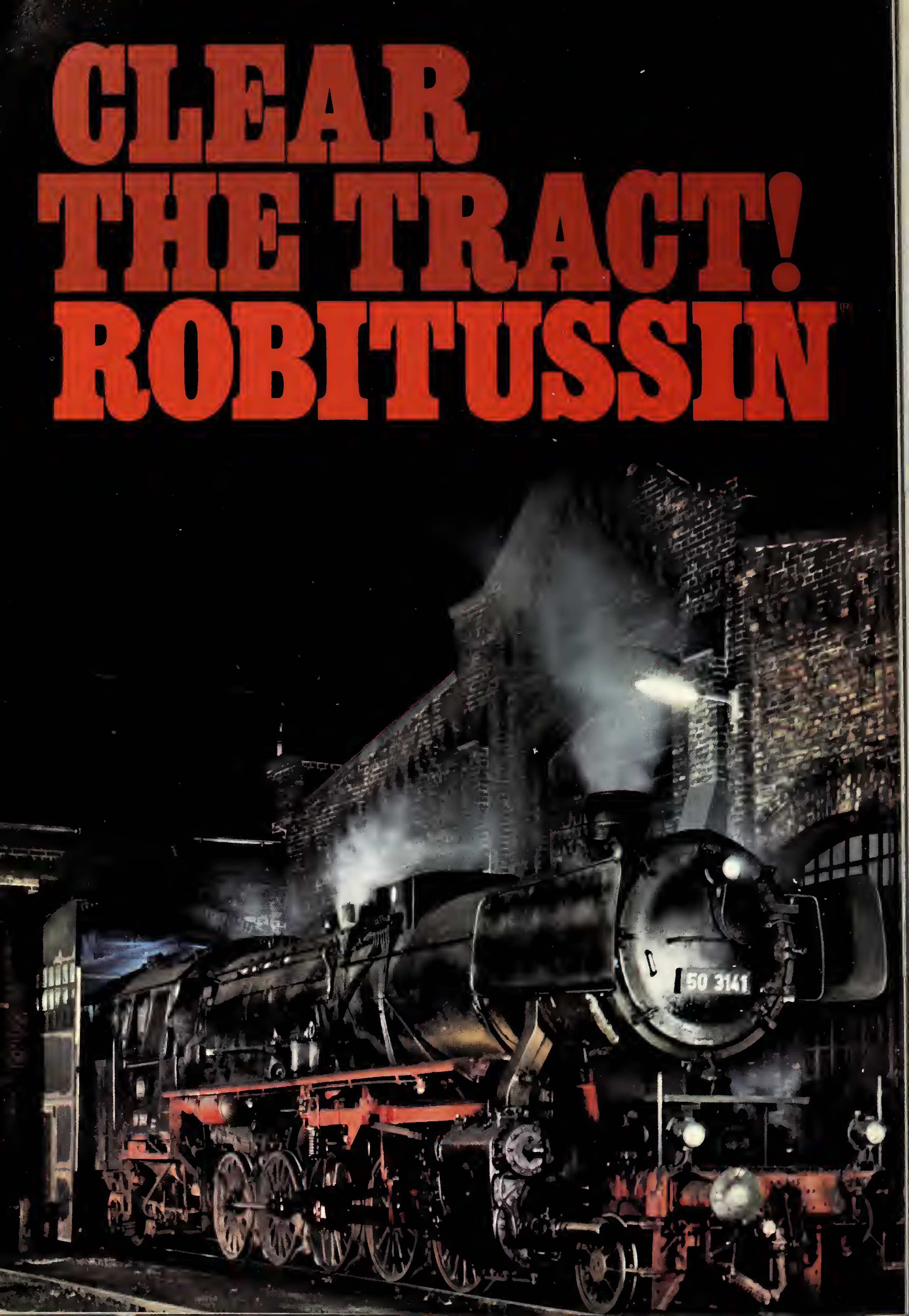
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For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.

Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.

(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Dextromethorphan hydrobromide .	15.0 mg.

Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Phenylephrine hydrochloride . . .	10.0 mg.

Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

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A. H. Robins Company, Richmond, Va. 23220

A-H-ROBINS

ENELOW NAMED CHAIRMAN OF PSYCHIATRY AT MSU

A California psychiatrist has been named to serve jointly as director of the Mental Health Unit at St. Lawrence Hospital, Lansing, and as chairman of the Department of Psychiatry at Michigan State University.

Allen J. Enelow, M.D., was professor of psychiatry and director of the postgraduate division of the USC School of Medicine, and also director of the Psychosomatic Service, Los Angeles County General Hospital.

Doctor Enelow was formerly chairman of the Section of Psychiatry and Neurology of the California Medical Association and is currently chairman of the Section on Nervous and Mental Diseases of the American Medical Association. He is the author of numerous professional articles and a book, "Psychiatry in the Practice of Medicine." He received his M.D. degree in 1944 at the University of Louisville.

Construction is scheduled to begin early next year on a $2.5 million facility which will enable St. Lawrence to expand its services.

HOSPITAL AUXILIARIES HEAR WILLS, DOHERTY

Ralph T. Wills, director of Community Relations of the Michigan State Medical Society, recently addressed the West Central District Meeting of Michigan Hospital Auxiliaries in Ludington. His talk was titled "Wanted: People Who Want to Help People."

About 100 Auxiliary leaders attended, and also heard comments about the Michigan Health Careers Mobile by John A. Doherty, Executive Di-

MARMP BOARD EXPRESSES APPRECIATION TO SIBERY

The Board of Directors of the Michigan Association for Regional Medical Programs, Inc., has unanimously passed a resolution honoring D. Eugene Sibery, extending to him its "deep appreciation for his sound judgment, skillful guidance, and invaluable experience, all of which were indispensable to MARMP, Inc. . . ."

Mr. Sibery served as project coordinator pro tem, helping to establish and develop the organization of MARMP, Inc.

Albert E. Heustis, M.D., former state health commissioner, is now the full-time director of MARMP. Mr. Sibery is now executive director of the Greater Detroit Area Hospital Council, Inc.

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In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS

Paul T. Chapman, M.D., left, TB Controller for the City of Detroit, receives the 1967 Bruce H. Douglas Award from Edward G. Nedwicki, M.D., President of the Michigan Thoracic Society and Chief, Pulmonary Disease Section, Veterans Administration Hospital, Allen Park. The award was presented to Doctor Chapman at the MTS annual meeting held in conjunction with the Mississippi Valley Conference on Tuberculosis at Grand Rapids, October 4-6.

Thoracic Society Gives Award to Chapman

Paul T. Chapman, M.D., TB Controller for the City of Detroit, was presented with the 1967 Bruce H. Douglas Award at a joint dinner meeting of the Michigan Thoracic Society and the Michigan Tuberculosis and Respiratory Disease Association during the annual meeting of the two associations in Grand Rapids.

The Bruce H. Douglas Award is presented annually by the Michigan Thoracic Society in recognition of outstanding contribution in the field of tuberculosis treatment or control in Michigan. Edward G. Nedwicki, M.D., Chief, Pulmonary Disease Section, Veterans Administration Hospital, Allen Park, made the presentation to Doctor Chapman for his efforts in tuberculosis control in Southeastern Michigan, assistance to the state legislature in passing necessary legislation for the control of tuberculosis and providing leadership in the voluntary health field.

Doctor Chapman is the immediate past-president of the Michigan Tuberculosis and Respiratory Disease Association.

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The Fast, Accurate and Inexpensive method for the following tests — **True Glucose — Hemoglobin Test — Cholesterol Test — Ureanitrogen Test (B.U.N.) — Uric Acid Test — Bilirubin Test.**

Something new has been added!

Total Protein Test — Globulin Test — Alkaline Phosphatase Test.

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NATIONAL MAGAZINE DESCRIBES M/M EFFORT TO PROMOTE CONVENTION

Michigan Medicine made another national magazine recently — the *World Convention* publication of the Hendrickson Publishing Company. Widely read in the billion-dollar convention market, *World Convention* described one of the features of the July issue.

In suggesting the idea to other associations, the trade journal declared:

"The July issue of *Michigan Medicine* embraced a 16-page section, printed on blue paper, which comprised the program of the 1967 Scientific Session of the Michigan State Medical Society. Separately stapled for easy pulling out, it included five pages of articles and news items about the convention."

SYMPOSIUM ON BLOOD AT WSU, JANUARY 19-20

Wayne State University's Sixteenth Annual Symposium on Blood, sponsored by the School of Medicine Department of Physiology and Pharmacology, will be held January 19 and 20, at the McGregor Memorial Conference Center.

"Fibrin, Fibrionolysis and Blood Coagulation" will be the theme of the program. Twenty-two papers will be presented by scientists from nearly as many universities, hospitals, and laboratories.

Walter H. Seegers, M.D., the William D. Traitel Professor of Hematology and Chairman of Physiology and Pharmacology at the Wayne State University School of Medicine, is chairman of the symposium committee. A complete program can be obtained from him at Wayne State University, School of Medicine, 1400 Chrysler Freeway, Detroit 48207. Tel: (313) 965-2860

MICHIGAN MAN APPOINTED TO FEDERAL COMMISSION

George E. Cartmill, Jr., Detroit, has been named to President Johnson's newly-created advisory commission on the nation's long-range needs for health facilities.

Mr. Cartmill is president of Harper Hospital in Detroit and is a past president of the American Hospital Association.

SAYS NATION NEEDS EDUCATIONAL RESEARCH

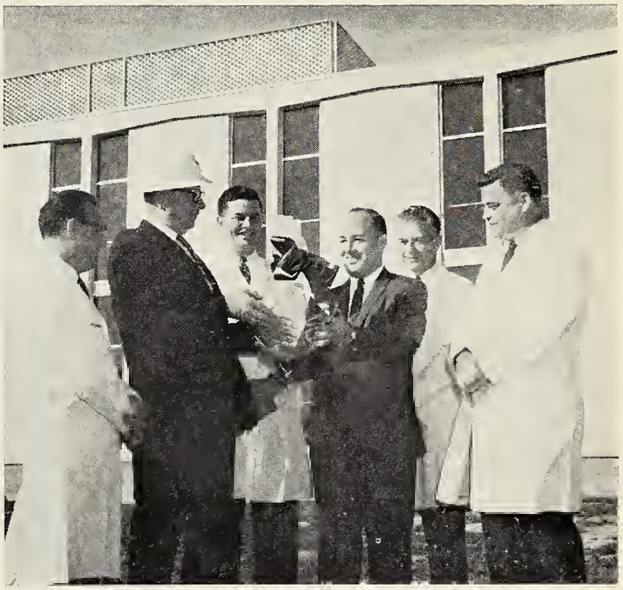
Research laboratories are needed across the country to help improve educational systems, declared Francis Keppel, former U.S. commissioner of education, in an address recently at the University of Michigan.

Education suffers, he said, from an inadequate supply of facts on which to base policies and programs.

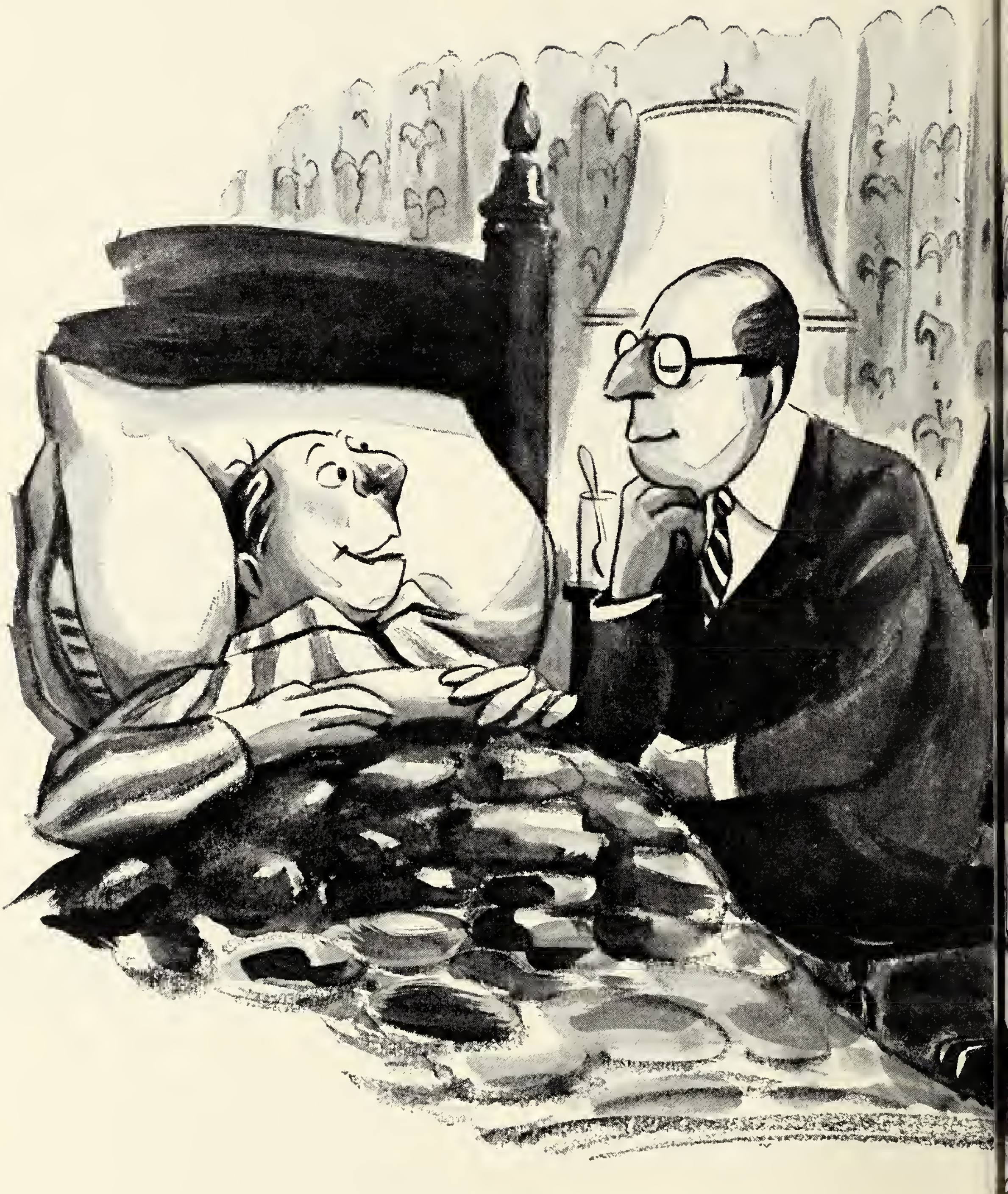
Planning and testing are needed, he said, and "the establishment of educational research and development laboratories may provide a setting for such development and testing."

He added that real planning has been rare in educational systems because daily demands have been so great and economic support has been so uncertain that long-term planning has seemed an "exercise in futility."

Mr. Keppel said, "the research programs should be responsive to problems defined by state and school authorities" and basic research should be done by the national government.

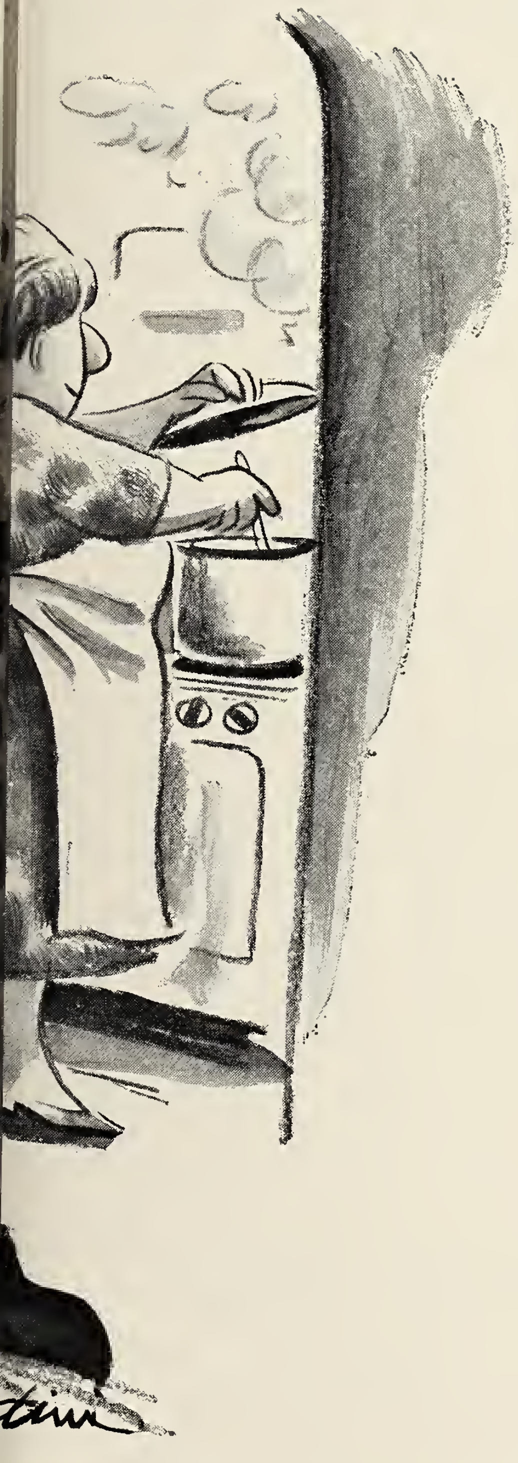


Symbolizing the completion of a $2.6 million addition to A. H. Robins Company's research center in Richmond, Construction Manager Joseph Noonan presents a large flask to Assistant Vice President Carl Lunsford, M.D., director of the center. The new wing contains approximately 54,000-square feet of space, doubling the size of the facility opened in February 1963. A. H. Robins conducts research in four general disciplines — chemistry and biochemistry, pharmacology, microbiology, and pharmacy and analytical research — and employs more than 120 scientists and technicians.



"When I couldn't even smell corned beef and cabbage,
I decided it was time for you, Doc."

Say you saw it in Michigan Medicine



Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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—Are there towns in your area in need of additional physicians?

—If your answer is YES to any of the above questions, contact

Michigan Health Council
John A. Doherty, Executive Secretary
712 Abbott Rd., P.O. Box 431
East Lansing (Phone: 337-1615)

(No charge for this service)

HEALTH COUNCIL TELLS STORY OVER TV PROGRAMS

The Michigan Health Council has arranged and participated in more than 1,000 television programs throughout Michigan since 1948.

During the past five years, the Council staff has arranged to have a health topic discussed every Thursday noon on "The Shirley Show," WZZM-TV 13, Grand Rapids-Muskegon; and also every Friday at 1:15 P.M. on "Accent" over WWTV-WWUP-TV, Channels 9-10, Cadillac-Traverse City-Saulte Ste. Marie.

Most of the Council's member organizations have participated in these telecasts enlightening viewers on a wide number of health topics. One of the most popular series presented were eight pre-natal education telecasts for expectant mothers. Thousands of prospective mothers viewed the series.

TWO MSMAS LEADERS NOW CERTIFIED MEDICAL ASSISTANTS

Two Michigan medical assistants were named "Certified Medical Assistants" at the 1967 Convention of the American Association of Medical Assistants held recently in Los Angeles.

So honored were Mrs. Nelda B. Gasperson, Mount Clemens, and Miss Phyllis L. Marquardt, Kalamazoo. According to AAMA Certifying Board Chairman Mrs. Mary Kinn, Santa Anna, California, "Certified Medical Assistants have achieved the highest professional level and thus are rated as the best qualified and most highly skilled medical assistants in the nation."

Mrs. Gasperson and Miss Marquardt were two of 74 medical assistants in the nation receiving the certification.

THREE MICHIGAN MEN SPEAK AT UTILIZATION REVIEW CONFERENCE

Three Michigan authorities played major roles at the National Conference on Utilization Review held recently in Houston, preceding the AMA's Clinical Convention.

In keeping with the theme of "Quality, Utilization, and Fiscal Review — Whose Responsibility?" Vergil N. Slee, M.D., Ann Arbor, presented an assessment of utilization review vis-a-vis the medical audit. Doctor Slee is director of the Commission of Professional and Hospital Activities.

Beverly C. Payne, M.D., assistant dean of the University of Michigan School of Medicine, described the specific criteria designed to overcome the inflexibility of "norms" and the inherent bias of individual surveyor's opinions.

The president of Michigan Blue Shield, John C. McCabe discussed current efforts to develop review techniques and the use of those techniques.

The one-day meeting was the second such conference sponsored by the American Medical Association.

Nesbit Soon to Terminate 44 Years with U-M

Reed M. Nesbit, M.D., Ann Arbor, internationally-known urologist, will officially end his 44-year career at the University of Michigan on January 1, 1969. Doctor Nesbit's retirement will come at the end of a year's leave.

Doctor Nesbit, now professor of surgery and head of the Department of Urology, will be 70 on December 8, 1968.

Medical School Dean William N. Hubbard, Jr., M.D., reports, "There are 76 former residents who count themselves most fortunate to have been close to Doctor Nesbit. Eighteen of his trainees have gone on to become urology chiefs at other medical schools throughout the world."

Doctor Nesbit is the recipient of numerous honors and awards presented throughout his lifetime for his numerous contributions to many phases of medical activity.

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Vhat Are Serious PR Problems Facing Medical Profession? What Are Solutions?

The AMA recently conducted a survey asking "What do you believe is the medical profession's most critical public relations problem and what suggestions do you have for solving it?"

That was one of the questions on a recent AMA ırvey of 4,000 county and state medical society fficials and the results were revealed at the recent MA Communications Institute in Chicago. The ırvey also sought suggested solutions and they ere reported too.

Three problems were the overwhelming winners:

1. **Physician-Patient Relationship**
2. **The Cost of Medical Care**
3. **The Shortage of Physicians**

Close on their heels were two others:

4. **Lack of Community Participation by Physicians.**
5. **Public Image of the Doctor as a Wealthy, Conspicuous Consumer.**

Let's look at those one at a time.

UNDER DOCTOR-PATIENT RELATIONSHIP, ociety executives listed these problems:

Doctors don't spend enough time with patients . . doctors are overloaded with work . . . patients ave long waits in the reception room . . . they lon't know what they're paying for and don't know ow much they're going to have to pay until they et the bill . . . doctors are frequently not available . . they don't make house calls . . . patients feel hat doctors don't care for them they way they'd ike to be cared for . . . and doctors are trained to reat illnesses instead of treating people with illesses. There were others, but those pretty well ummarize the problems.

Fortunately, there also were a lot of solutions uggested:

Find ways to teach the public what high quality edical care really means and how to identify its omponents . . . put more emphasis on the physiian's concern — concern for his patients, for the lderly, for the young and for the community . . . make every physician aware that public relations tarts in his office . . . spend more time with patients . . . develop more family doctors . . . change MD's attitudes and return to something resembling the old family doctor, who is now extinct . . . prove that MD's are interested in people . . . train office irls to be more sympathetic and courteous . . .

Finally, one executive said that if every MD gave every patient satisfactory care at a reasonable cost, it would solve all of the problems of medicine's image and relationships with patients.

THE PROBLEM OF THE COST OF MEDICAL CARE are these, according to the survey:

Many people believe that the sole interest of physicians is to maintain the form of practice that assures them the most money . . . the public believes that everything done by every MD carries a price tag . . . doctors are blamed for the high hospital and drug charges as well as for their own fees . . . and doctors appear more interested in the financial aspects of medicine than in their patients.

Many solutions were suggested: explain all factors of the rising cost of health care . . . show that medicine's aims are based on public need . . . undertake long-range programs to cope with rising costs . . . continue educational programs to sell the value of medical care . . . and use the fee plaque. An interesting contrast came in two suggestions—one, that doctors explain direct billing; the other, that doctors stop insisting on direct billing.

THE SHORTAGE OF PHYSICIANS comments included: people can't get a physician in an emergency . . . the public is not convinced that health care is available day and night . . . and people do not understand the shortage of GP's and increasing specialization.

The solutions offered included these: provide 24-hour emergency coverage and make sure the public knows how to use it . . . long-range programs to cope with physician shortages . . . explain why the shortage exists . . . try to get more doctors . . . implement the Millis report . . . activate rural emergency service programs . . . and encourage more partnerships and group practice.

The findings under **PHYSICIAN IMAGE** and **COMMUNITY INTEREST** are closely allied. These were listed as the major problems:

The nationwide effort to discredit the profession . . . necessary changes in the practice of medi-

Continued on 1614

The AMA librarians are skille at compiling bibliographies to assist physicians with their practic and with their continuing education.

Extensive AMA Library Offers Many Services to Members

Physicians, when you need to do research on a particular medical issue, the AMA's Archive-Library is on call to serve you. A letter, telegram, or telephone request is all that is necessary to put its varied resources at your disposal.

In brief, the AMA Library has three basic aims: (1) conduct medical literature searches, (2) compile bibliographies, and (3) provide photocopies of articles.

THE PRIME OBJECTIVES of the Library, however, are to serve as an adjunct to the postgraduate education of the practicing physician and also as a resource center for the community. The large medical library, with its well-established communication channels to the medical profession, is in a unique position to provide specialized services not normally available.

In addition, a large staff of consultants works with the AMA Library to fulfill the concept of an information center. In numerous fields — for example, medical physics, cardiology, psychiatry, and drug therapy — physicians on the AMA staff evaluate and often digest information before it is delivered to the user.

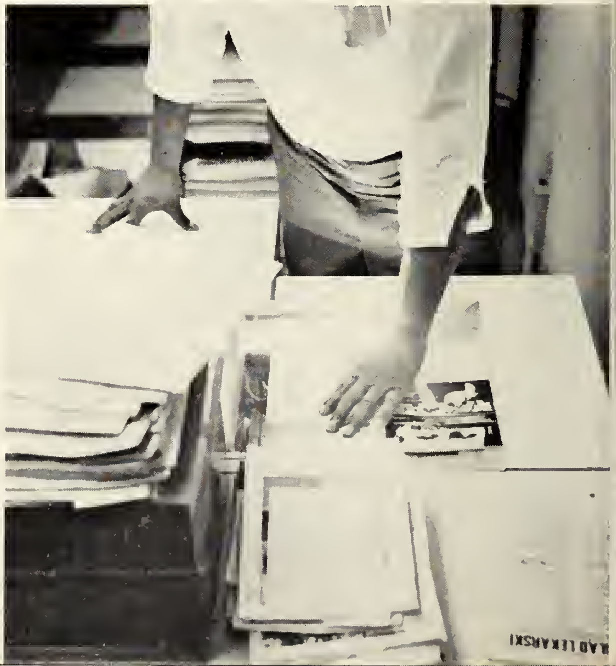
Requests for information requiring medical opinion are referred to various authorities throughout the nation by the Questions and Answers Department of *JAMA*.

In the field of clinical medicine the Library assists the physician in his practice and research by utilizing the resources of its 2200 journal subscriptions and 40,000 books as well as the subject expertness of the Association's 20 scientific departments.

In order to help the doctor in patient care, the collection reflects the current rather than the historical, and with the exception of selected titles journal sources data back no later than 1956 For reference to this type of information published before 1956, the Library acts as a clearinghouse, referring members to local centers or the National Library of Medicine.

One of the Library's most valuable assets is its collection of medical socio-economic source materials. In recent years the Association has methodically gathered and indexed in depth one of the

The AMA library staff will send photocopies of articles requested by AMA members.



vorld's largest collections in the sociology and conomics of medicine. Complete coverage of all nglish language publications is attempted, inluding opinions reflected in mass media publicaions as well as in scholarly works. This special ollection alone presently contains over 20,000 tems.

FOR THE PHYSICIAN travelling overseas on abbatical, to practice, or to attend an internationl congress, the Library is able to assist him in the many areas of international health. Up-to-date files are maintained on foreign medical organizations, hospital, and medical facilities in various countries, living conditions, what one should bring, where the nearest American physician may be located, etc. For the American physician living abroad, the Library provides research and photocopy services on specific medical subjects.

In addition, the international health section compiles the most comprehensive and up-to-date listing of medical meetings outside the United States, and this list is published weekly in *JAMA*. All information pertaining to meetings, etc. is verified with the originating organization before publication.

THE ARCHIVES DEPARTMENT houses documents and artifacts including complete papers of commissions and original policy documents as well as books, journals, and pamphlets. Medals, trophies, portraits, and taped interviews are housed in a museum and in revolving displays through the building. This collection is used by physicians and historians throughout the world.

Another valuable role the Library plays is that of creating and maintaining information channels with the communications media. An important aspect of the public's health education is dissemination of authoritative information.

The Library's collections are made available by sending facsimiles which the physician may keep for his files. As a general rule, original materials remain in the Library at all times. In keeping with copyright laws, multiple copies of a document cannot be provided.

AMA OBJECTS IN 1847 STILL THE SAME TODAY

In 1847, the year the AMA was founded, only 29 states had been admitted to the Union . . . James Polk, our eleventh President, was in office . . . the first U.S. postage stamps had just been printed . . . and Charles Dickens was writing *David Copperfield.*

Formalized medical education was practically non-existent. Men boasted they could—and actually did—buy medical degrees for a little cash. Many who hung up shingles had no medical training at all. Medical quackery and traffic in patent medicines were rampant. The medicine man vied with the doctor of medicine for patients' attention. There was no recognized code of ethics for physicians.

THEN, AS NOW, reputable physicians were seriously concerned about the state of medical affairs in the nation.

In 1847, two hundred fifty physicians, representing more than 40 medical societies and 28 colleges, embracing medical institutions in 22 states, met in the Academy of Natural Sciences in Philadelphia.

The physicians gathered in Philadelphia felt that a national association of doctors was needed to lead the crusade for better medical care. With 30-year-old Dr. Nathan Smith Davis of New York as its founder, the American Medical Association was organized on May 5, 1847.

THE BASIC OBJECTIVES of the AMA today are the same as those written into the Association's Constitution more than a century ago: "to promote the science and art of medicine and the betterment of public health." AMA's primary goals are better health for all people, and service to the professional needs of members.

(Editor's Note: The above copy is quoted from an AMA publication, "The AMA — Promoting the Science and Art of Medicine and the Betterment of Public Health." Copies may be obtained from the MSMS Headquarters.)

WRITE, VISIT THE AMA LIBRARY

To take advantage of this enormous opportunity to obtain current information, or information of historical interest, Michigan physicians may contact the Archive-Library, whose address is the same as the general AMA address: 535 N. Dearborn Street, Chicago 60610. Telephone number is area code 312, 527-1500.

Better still, Michigan physicians when in Chicago may visit the Library and familiarize themselves with its staff, sources, and services. It is open Monday through Friday, 8:30 a.m. to 4:45 p.m.

cine have not been explained to the public . . . physicians lack time and means to convince the public that MD's are not entirely concerned with money . . . doctors are so preoccupied with their tarnished image, and talk about it so much, that they have convinced their friends and business acquaintances that it's true . . . the public does not understand why doctors oppose government programs or even government control . . . medicine has a negative image after years of battle over government health programs . . . when doctors oppose a program, the public think's it's because they can make more money another way . . . there is a lack of identity with community problems and the public can't see the profession doing anything about the problems people are talking about . . . lack of rapport with the public . . . not enough concern about the community . . . and medicine is too concerned with little problems and not concerned enough about really big ones in this country.

It is significant that few of these problems exist in the small medical society, where the doctors are well known in the community and are involved in community affairs . . . where they have time to chat a few minutes with their patients . . . and where they treat most of the various ailments of the entire family. The basis for the problems seems to be bigness . . . and everything in this country—except the dollar—is getting bigger all the time.

Here are the main solutions suggested: get across our views on current problems . . . let the public know our goals . . . see that welfare patients get care whenever they need it . . . explain the charges and services under Medicare . . . educate MD's and their wives in community relations . . . physicians should be leaders and not followers in the community . . . doctors need more contact with business people and with the public . . . help meet the health needs of the community . . . better liaison with welfare agencies . . . more school courses on VD and smoking . . .make the public aware of problems facing the physician . . . explain MD activities in promoting public welfare . . . find solutions to health problems at the local level . . . be totally involved in all facets of health care . . . And finally, make an intensive analysis of health care needs; develop sound programs to meet them; and conduct a campaign to see that the programs work.

And here is the brief recommendation of one executive as to what physicians must do in the face of their problems: maintain their cool and keep the faith!

(Editor's Note: Michigan Medicine is grateful to the AMA staff for permitting us to reprint the above commentary which was presented by AMA staffers to the Communications Institute.)

SAMA FAVORS $5,000 MINIMUM SALARY FOR INTERNS, RESIDENTS

The Student American Medical Association, which will hold its 1968 annual convention in Detroit, April 23-28, is working this year on a number of projects authorized by the 1967 SAMA House of Delegates.

The Standing Committee on Medical Education was instructed to study in depth the current philosophy of medical education from the student's viewpoint. The Committee will then suggest changes to accomplish the new goals established by modern medical needs. This study is to be the Committee's sole responsibility for at least one year.

The House recommended that a $5,000 minimum salary for interns and residents be made a condition for AMA approval of house staff training programs.

Strong support was given to the policy of allowing physicians to fulfill their military obligations by serving in the United States Public Health Service. A proposal was made to ask the USPHS to develop a program whereby a medical student could elect to serve an additional year above the required two years of Public Health Service in exchange for the financing of his senior year of medical education.

The SAMA House endorsed legislation to allow medically supervised therapeutic abortion if a board of three physicians believed that the continuation of pregnancy would endanger the life or health of the mother, if the pregnancy were the result of rape or incest, or if the pregnancy might produce a severely malformed child.

In the area of community health, the SAMA House requested that SAMA chapters investigate the socio-economic problems of poor people in their communities, especially as their problems relate to health. To implement this action an ad hoc committee on community health projects will be appointed to coordinate local programs and develop resources for the committees' efforts. The House also established a formal liaison with the national communications network of the Student Health Organizations having experience in this matter.

Additional information about the SAMA House action may be found in the October 1967 issue of *The New Physician.*

Contends Welfare Recipient "Actual Victim of the System"

"Often the intended beneficiary of welfare beomes the actual victim of the system. What were onceived of at the outset as rights and privileges ecomes duties and liabilities."

That viewpoint was expressed at the recent Conerence on Civil Liberties of Children and Youth t the University of Michigan by B. J. George, Jr., U-M Law School professor.

Much of the unfairness in administering welfare laws is a reflection of the dislike and fear of most people toward those who are or may be on relief, according to Professor George.

Without the greatest care, he said, injustice, though good-faith injustice, quickly becomes the chief product of the modern welfare system.

The welfare system, he said "needs complete revision. But as long as in the eyes of the taxpayers who control fiscal legislation the welfare recipient is a nonperson who embodies an ever-present threat to the fiscal system and the community itself, and in the view of welfare workers he is a case number that exists for the convenience of the system, due process will mean very little to those adults for whose supposed benefit it is invoked."

Welfare will mean even "less to the children who could not comprehend the system if they would, and who are the long-term victims of society's efforts to control morals through financial measures."

Custody legislation also needs revision, he said, "but so-called parents' rights are likely to be of greater value in the eyes of legislators than any right of the child to have his best interests directly considered."

Injustices also arise in school administration, said Professor George, where there are "at least three classes of problems that might well be examined."

First, he said, the degree to which minority religious groups can be permitted to maintain special schools that do not meet minimum state standards must be decided. If groups such as the Amish or Hasidic Jews are permitted to maintain a separate identity "one might argue that there should be room for a typical religious expression."

The grounds and procedures for expelling students from a public school also merit attention as do the content of disciplinary regulations themselves.

"It is entirely possible," he said, "that a controlling principle might be laid down that school regulations to be enforceable must bear directly on health and safety, and not rest on some undefined concept of morality or propriety."

Prof. George said that after a leading court decision has been made follow up must take place "through new local legislation and amended administrative regulations.

"True reform cannot be achieved through litigation," he concluded, "and the only lasting solution is one resting on widely-held community values."

Turning to the apparent injustices of the present system, Prof. George said "the juvenile court is a classic example of an institution conceived in a semi-religious glow of exaltation, reared in an atmosphere of almost complete parental neglect and now the object of intense efforts to rehabilitate it as a useful part of the system."

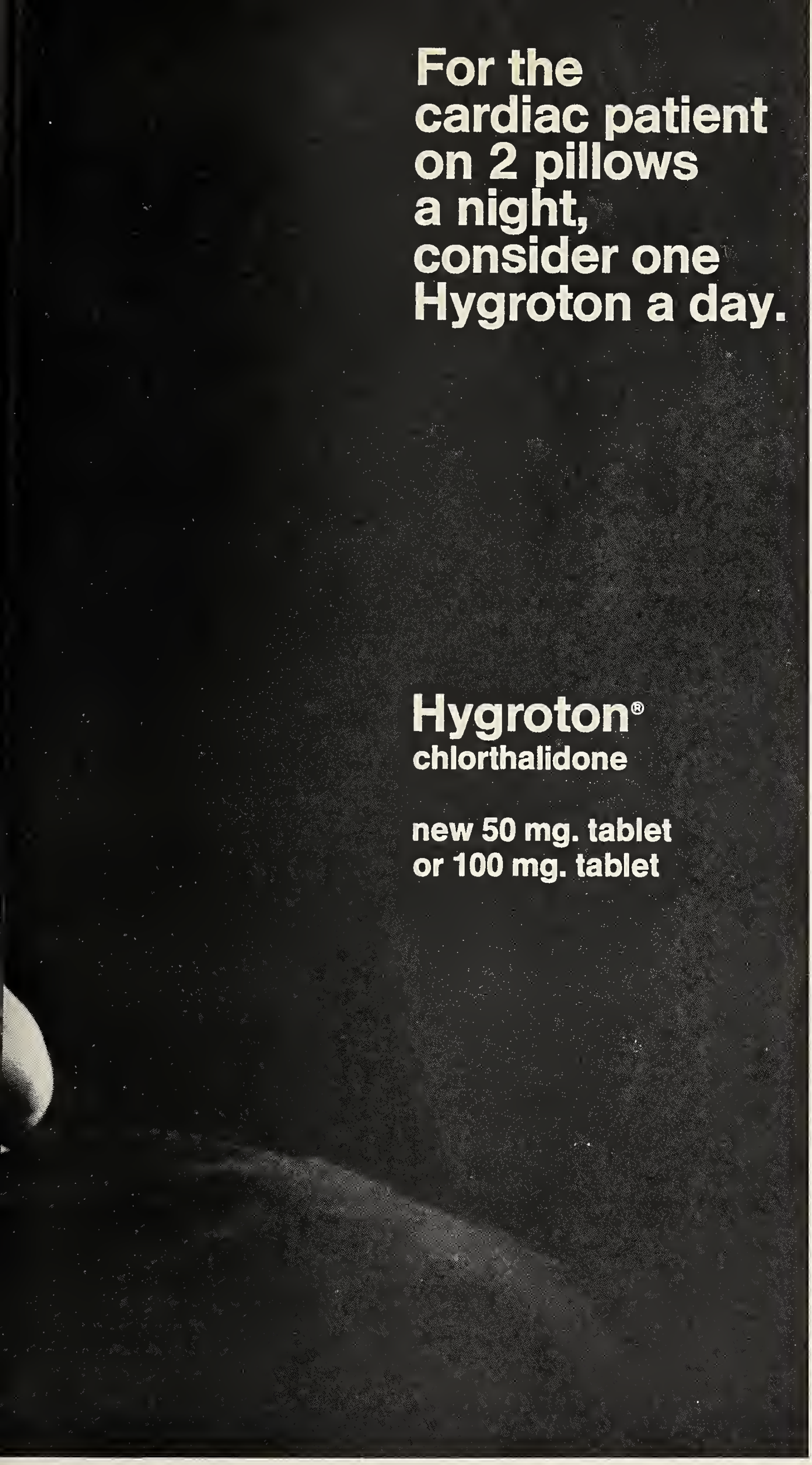
In the recent Gault case, the U.S. Supreme Court extended to children many of the rights of adults including the right of notification of charges in writing, the right to be confronted by witnesses, and the right against self-incrimination.

Calling this decision the start of a revolution in juvenile court legislation, Professor George predicted that it will not be confined to delinquency proceedings.

"If notice is required for a delinquency proceeding," he said, "there is no reason not to expect some form of notice in any other juvenile court proceeding. If right to counsel is important to a delinquent, it is equally important if parents may lose custody of their child or if the child is to be removed from his environment; the corollary is that the parent and the child must each have his own attorney."

Juvenile officers working closely with welfare authorities may be forced to comply with a favorable judicial decision, he said, but the price may be "months or years of official interference with liberty of action" for the individual or family.

Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.
Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.
Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take special care in cirrhosis or



For the cardiac patient on 2 pillows a night, consider one Hygroton a day.

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or 100 mg. tablet

She was the picture of arteriosclerotic heart disease in failure.
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Then her breathing improved—
along with her urinary output.

Nights could be a lot more pleasant for patients like this in your practice.
Try it and see.

Hygroton therapy may also mean troublesome side effects for certain patients.
A summary of essential prescribing information is shown below.

severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)R46-230-D
For full details, please see the complete prescribing information.

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The color video tape recorder and color monitor, now in use by the Muskegon County Medical Society, is demonstrated by Robert Swedenberg, M.D., president-elect.

Muskegon Medical Society Begins Use Of Video Tape Recorder for Education

The Muskegon County Medical Society, with financial backing from the Muskegon Medical Foundation, has recently purchased an Ampex VR-7500 color video tape recorder and a color monitor to use in medical education programming.

"The unit is transportable and its potentialities for medical education are enormous. We foresee many valuable uses for this unit," says Robert Swedenberg, M.D., President-Elect of the Muskegon County Medical Society, presently in charge of the video tape recorder.

"Medical tapes are already available for postgraduate physician education," Doctor Swedenberg continued. "Because of this availability, we have not at present purchased a camera, but we will be renting one on a per diem basis when we want to make our own tapes."

"The unit will have many other medical education possibilities," Doctor Swedenberg said. "In-service nursing and para-medical education; hospital patient education via closed circuit television; teaching baby care to new mothers; giving instructions on home care and convalescence; recruitment of medical personnel and nurses; health education for the public in schools and on commercial television—these are just some of the uses we will have for it."

Operation of the unit will be in the hands of a hospital staff person.

In a day when the physician's time is more valuable than ever, medical educators are excited about video tape recorders. They can bring continuing postgraduate education to the physician in his own hospital. They can permit the physician to be a spokesman to his community about vital health matters. They can extend his effectiveness as a teacher. For example, instead of repeating a lecture to groups of nurses, the physician can give his lecture once, have it recorded, and then it can be replayed over and over to groups of nurses. His knowledge and judgement becomes instantly available and he can work at other things which demand his time and skill.

There is enormous potential also for communication between county and state societies. A tape made in Muskegon, for example, could be played in Alpena. All that would be required in Alpena would be a recorder and a monitor and, of course, a compatible model machine.

"The Muskegon experience with video tape re-

Continued on 1620

Before prescribing, see complete prescribing information in SK&F literature or *PDR.* A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.

a stuffy nose
is no
laughing matter

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules
brand of sustained release capsules

each one can
give him all-day
or all-night relief

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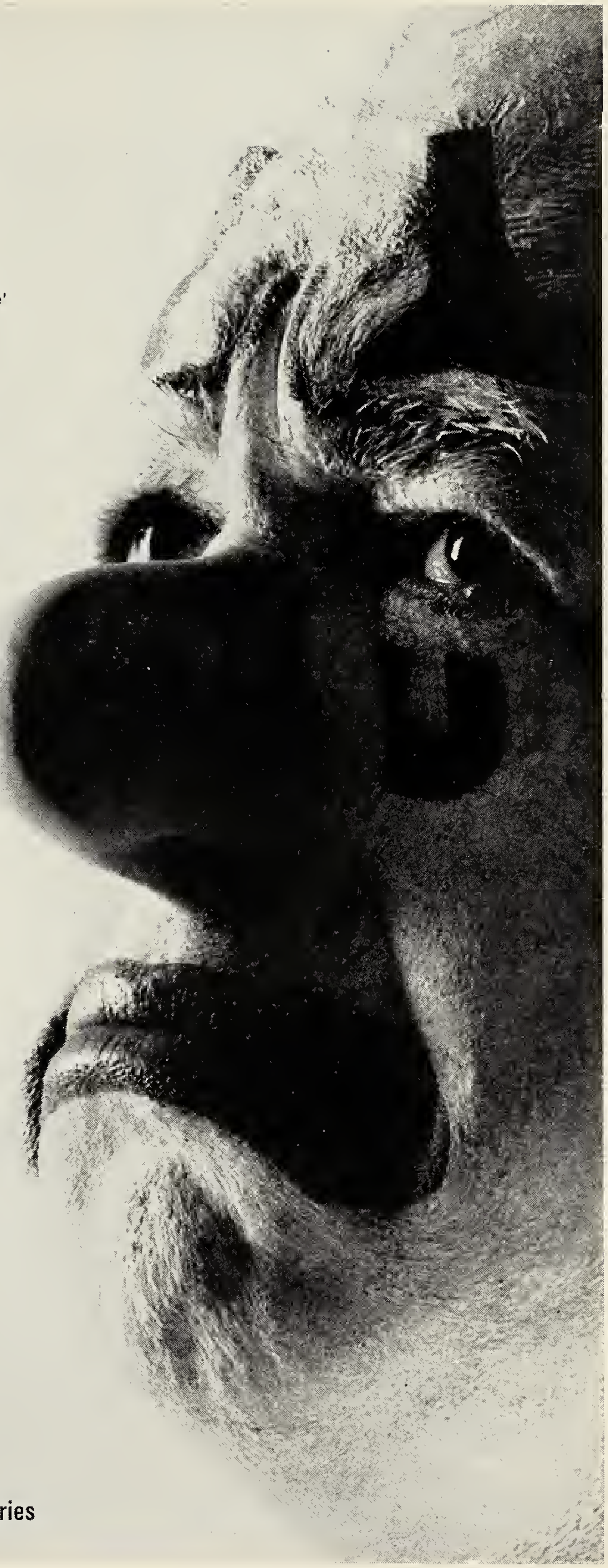

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ACETYLSALICYLIC ACID (ASPIRIN)..... 5 GR.
*PENTOBARBITAL (ACID)............ 1/8 GR.
*Warning: may be habit-forming

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

LITERATURE AND CLINICAL SUPPLY AVAILABLE TO PHYSICIANS

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MUSKEGON/Continued

corders will serve as an invaluable pilot program for county medical societies all around the state," MSMS officials have declared.

As the various uses for video tape recorders in medicine unfold, there is the possibility that a central tape library can be established at the MSMS headquarters so that tapes on a variety of subjects could be available to county societies on request.

A video tape recording unit contains three main pieces of equipment: a camera, recorder, and monitor (TV screen). The total package is in effect a miniature television studio.

The camera picks up the event to be taped. It can take either close, detailed shots or it can encompass a larger view, such as a group in discussion. The scene picked up by the camera is then transferred to audio-visual tape by the recorder. The taped event is simultaneously transferred to a monitor, where it can be viewed while it is happening. Later the finished tape can be replayed as often as desired or erased and used to record another event.

The Muskegon unit was purchased at a cost of $5,700.

WAYNE AUXILIARY HELPS DISTRIBUTE "HORIZONS UNLIMITED"

The MSMS Public Relations Committee is grateful for the assistance of members, auxiliary members and all others who help distribute the AMA *Horizons Unlimited* books.

The effective efforts of the Woman's Auxiliary to the Wayne County Medical Society are described in the 1966-67 annual report of the Health Careers Committee. The report by Mrs. Coleman Mopper, Chairman, said in part:

"With the aid of my committee, copies of *Horizons Unlimited* were distributed to all Junior and Senior High Schools in the Detroit, Dearborn, Highland Park, Royal Oak, Ferndale, Oak Park, Redford, Grosse Pointe, Farmington and Birmingham areas. In addition, I sent letters with the books to schools in locations that we could not contact personally. These books were well received with letters of gratitude as well as requests for additional copies.

"One hundred copies were delivered to Mrs. Rose Berman at Durfee School for distribution at the annual counselors conference. Our Board members also were most cooperative in placing *Horizons Unlimited* in their husband's reception rooms."

MALARIA CASES UP; CURRENT TREATMENT SUGGESTIONS OFFERED

Information about the treatment of acute attacks of malaria is offered Michigan doctors because foreign military involvement and extensive civilian world travel may bring the problems of malaria prophylaxis, diagnosis and possibly treatment to Michigan physicians at any time.

In the first nine months of 1967 a total of 1,553 cases of malaria were reported in the United States as compared with 342 for the same period of 1966. Eight of the 1967 cases were from Michigan, compared with nine for the same period of 1966. All of our cases were in returning veterans as are the majority of our country's cases. Former Peace Corps volunteers appear to rate second as a group.

This current information on malaria is reproduced for the information of physicians as furnished by Hans O. Lobel, M.D., Chief, Malaria Surveillance Unit, National Communicable Disease Center, Atlanta, Georgia. The information was given to *Michigan Medicine* by the Division of Epidemiology, Michigan Department of Public Health.

"In most cases, radical cure of infections due to *Plasmodium falciparum* and clinical cure of infections due to *P. vivax, P. ovale* and *P. malariae* can be achieved by oral administration of 2.5 grams of chloroquine phosphate (1.5 grams of base) in three days, to be given as follows:

"An initial dose of chloroquine phosphate, 1.0 gram (600 mg. of base), followed by 0.5 gram (300 mg. of base) six hours later, and then 0.5 gram once daily for the next two successive days. If the patient is unable to take or retain chloroquine given orally, the drug may be given as the hydrochloride, 250 mgs. intramuscularly, and repeated in six hours, switching as soon as possible to the oral medication. This regimen should be employed initially for patients with any type of malaria who are not critically ill and for whom the history does not indicate that such a course of therapy has already been administered.

"Radical cure of mosquito induced infections due to *P. vivax, P. ovale* and *P. malariae* can be achieved by the oral administration of 15 mg. of primaquine base (26.4 mg. of primaquine diphos-

removes the mental blur

that clouds vision

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Each tablet or capsule contains
PHENOBARBITAL..............16 mg.
(Warning: may be habit forming)
BENSULFOID ® (See P D R)......65 mg.
Precaution: same as 16 mg. of phenobarbital

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Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

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100s, 500s, 5000s
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phate) once a day for 14 days. In the treatment of acute attacks, the primaquine regimen should be initiated simultaneously with the administration of the chloroquine.

"Since 1961, chloroquine resistant strains of *P. falciparum* have been reported from areas of Colombia, Brazil, British Guiana, Cambodia, Malaya, South Vietnam, and Thailand.

"In patients with *P. falciparum* malaria who a) are gravely ill, or b) have not responded to the chloroquine treatment described above, or c) have a recrudescence despite a previous response to a course of chloroquine, the treatment of choice is quinine. This is administered as quinine sulfate 0.65 gram (two tablets of 5 grains each) every eight hours for seven to ten days. Because of a variable tendency to develop postural hpyotension, patients should be kept at bed rest during quinine administration. The urine output should be measured and if oliguria develops, quinine should be temporarily discontinued. During oliguria, quinine blood levels may rise precipitously and acute quinine toxicity may ensue.

"If the patient is unable to retain quinine because of vomiting, or when coma, presumed due to falciparum malaria, is present, the drug may be given intravenously. It must be emphasized that this treatment carries a *serious hazard* and should be resorted to only when the patient's condition clearly warrants the risk and no other form of treatment is possible. Quinine is administered intravenously as the dihydrochloride, 600 mg. in 600 cc. of normal saline, by *very slow* intravenous drip with constant monitoring of the blood pressure and the pulse to detect hypotension or arrhythmia. The same intravenous dose may be repeated at intervals of eight hours if the patient's condition requires. Oral therapy, by stomach tube if necessary, should be utilized as soon as possible.

"Patients who respond to quinine therapy but later undergo recrudescence should be retreated with quinine as described above. If necessary, the course of quinine may be maintained for 21 days at a dosage of 0.65 grams (10 grains) every eight hours, as tolerated.

"In cases of treatment failure following 21 days of quinine or in patients unable to tolerate quinine, an alternative treatment regimen should be considered such as a course of pryimethamine (Daraprim), 50 mg. daily for *three days* concurrently with sulfadiazine, 0.5 gram every six hours for five days or other conventional long acting sulfonamides. Careful attention should be given to maintaining adequate hydration during this therapy.

"A number of drugs are undergoing field trials to determine their efficacy as additional antimalarials, including sulphormethoxine and diaminodiphenylsulfone (DDS). These drugs are not now commercially available.

MALARIA CHEMOPROPHYLAXIS

"As a general guideline, malaria chemoprophylaxis is indicated for persons residing permanently or temporarily in countries where malaria transmission occurs. However, it should be recognized that malaria transmission does not necessarily occur throughout the entire country and that local conditions will to a large extent dictate the need for chemoprophylaxis.

"A weekly dose of 300 mg. chloroquine base taken orally starting the week prior to exposure and continuing four weeks after leaving the endemic area is recommended. This will provide complete protection against *P. falciparum* with the exception of those strains which have acquired resistance to the drug. Infections caused by *P. vivax, P. malariae* and *P. ovale* will be suppressed by this regimen and the possibility of clinical malaria developing after cessation of chemoprophylaxis must be recognized. In this event therapy with chloroquine followed by 15 mg. primaquine base orally once a day for 14 days will eliminate the parasite in most cases.

"An excellent and up-to-date review of the subject has been published by Dr. Robin D. Powell: "The Chemotherapy of Malaria" in *Clinical Pharmacology and Therapeutics,* Vol. 7, No. 1, pp. 48-76, January-February, 1966. Dr. Powell's address is Department of Medicine, Division of Biological Sciences, University of Chicago, Chicago, Illinois.

"Following is a list of countries where malaria transmission occurs or might occur (*WHO,* June 1966).

Western Hemisphere

1) Mexico and all countries of Central America.
2) All countries of South America excepting Chile and Uruguay (note—Argentina: malaria present only in northern portion of the country bordering Paraguay and Bolivia).
3) Caribbean—Cuba, Haiti, Dominican Republic.

Africa

All countries including Madagascar but excluding South Africa and Libya.

Near East

Turkey, Iraq, Iran and Saudi Arabia.

Asia

Afghanistan, East and West Pakistan, India, China, North and South Korea, Nepal, Burma, Thailand, Malaysia, Cambodia, Laos, North and South Vietnam, Indonesia, Sarawak, Philippines, New Guinea, Solomon Islands and New Hebrides."

after surgery

B and C vitamins are therapy: Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS capsules, designed to meet increased metabolic demands, aid in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

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Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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When the agitated geriatric disrupts the home...

His teen-age granddaughter won't invite friends home because of his outbursts.

for moderate to severe anxiety

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(thioridazine)

25 mg. t.i.d.

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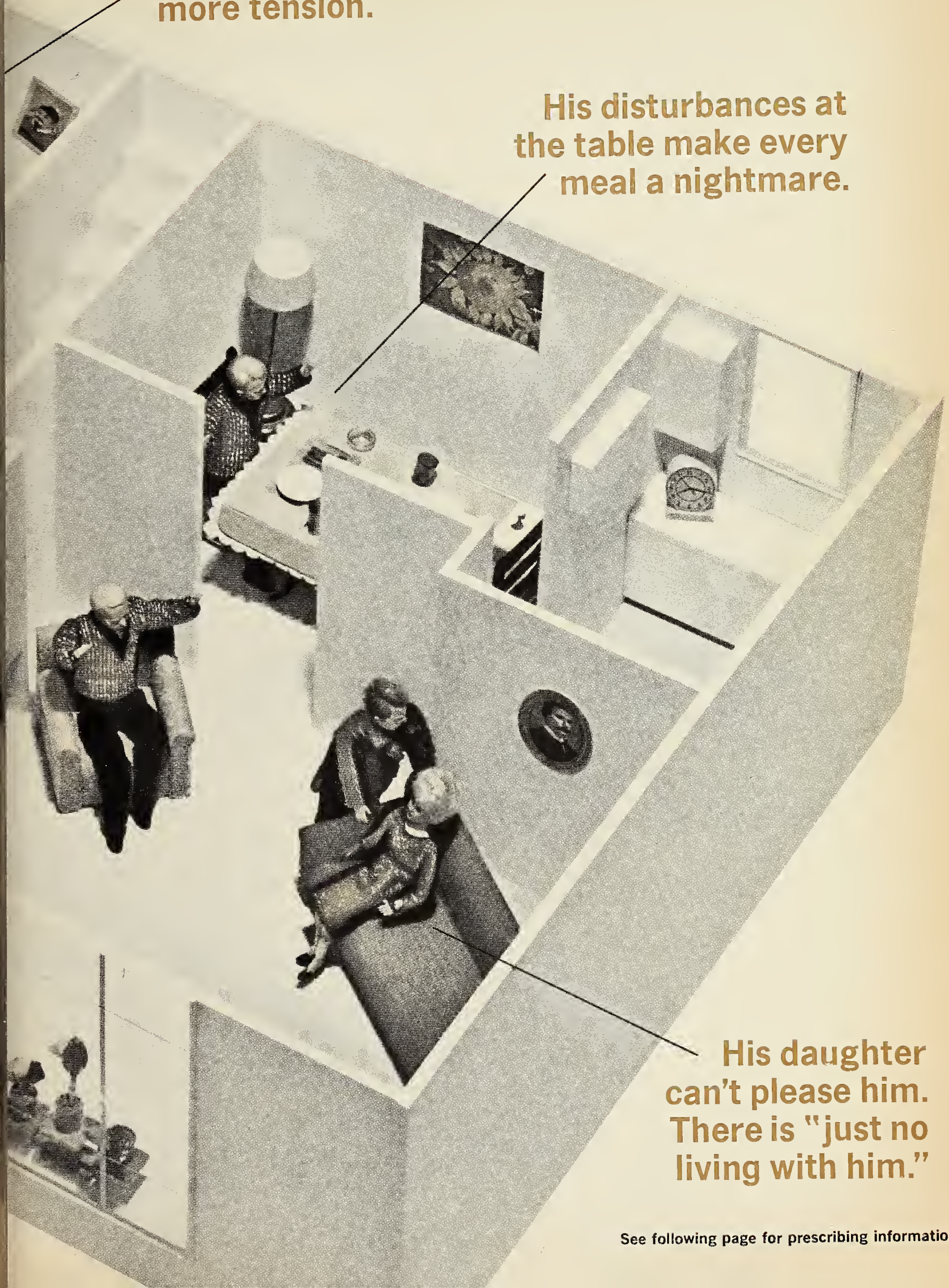

His slovenly room and habits create more tension.

His disturbances at the table make every meal a nightmare.

His daughter can't please him. There is "just no living with him."

See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

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The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
Ephedrine HCl	16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

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mail bag

In response to the viewpoint expressed by Dr. eorge H. Lowrey entitled "The Dangers of deno-tonsillectomy," I feel this "danger" can be nswered in two words . . . practically none!

In this day of endotracheal anesthesia and elecro-coagulation of bleeding points the procedure hould cause a minimum of problems to a doctor rained in throat surgery.

As to the value of tonsillectomy and/or adenoilectomy, I would simply ask the parents of our oung patients these questions:

(1) Has your child missed less school time from hroat infections since the T & A?

(2) Has your child had less ear trouble since the T & A?

(3) Has your child discontinued his mouth breathing and "stuffy" speech since the T & A?

In my practice the answer to these questions is a resounding *yes!*

I know of no otolaryngoloist who advocates the "family plan" or the routine scheduling before starting school. Each patient should be evaluated individually so that unnecessary surgery can be avoided.

In discussing two procedures which should be considered practically worthless, I offer these two in particular:

First, the needless allergic testing and prolonged treatment for nasal obstruction in children due to blocking adenoid tissue.

Secondly, the use of huge volumes of antibiotics administered for the child with serious otitis media. Therefore adenotonsillectomy is the wisest course of treatment in many of the ENT problems troubling the pediatric age patient.

Sincerely,
Robert D. Burton, M.D.
Chairman of ENT section MSMS 1966-1967,
Grand Rapids

I feel the article in *Michigan Medicine* on "Cutaneous Complications of Smallpox Vaccination" by Doctors Coskey and Bryan was timely and well done. It emphasized, as it should, the complications of smallpox vaccinations because physicians practicing in the United States haven't seen smallpox since 1949. This has been due to our ongoing smallpox vaccination program and our quarantine system that requires all people entering the United States to have a valid certificate of vaccination. Recently, the requirement for this for Mexico was lifted. However, one must remember that in terms of time our world is smaller today. In a day's travel, one can be in areas of the earth where smallpox is endemic, if not epidemic.

In those areas one-fifth to one-fourth of the complications of variola is death. Almost all end up scarred for life. The primary cause of facial disfigurement is smallpox not acne. Blindness as a result is not uncommon. Treatment is usually wanton. The only factor that has kept this disease under control has been vaccinations in the involved countries and elsewhere.

Until we have wiped out these major reservoirs of smallpox in the world, we should continue to vaccinate 14,014,000 people yearly in the United States against smallpox.

Smallpox vaccination is not contraindicated in tuberculosis. It should not be used in active cases with open lesions. There is no reason, however, why a child with a positive tuberculin reaction of 10 mm or more should not be vaccinated against smallpox.

If we were to follow the same recommendations of the authors' regard—not giving it to tuberculosis cases, then physicians shouldn't vaccinate against it in the countries where it is endemic. These smallpox ridden countries have active tuberculosis case rates as high as 10% of the population. Frequently the tuberculin reactor rate will exceed 90%.

In my experience, frequently, the first indication that a child has hypo or dysgammaglobulinemia was when the child had an unusual reaction to smallpox vaccination. In fact, when it does occur the physician should consider this first. In effect it isn't the vaccination that is the problem, it is the inability of the patient to develop immunity.

If the vaccination levels are not maintained, utilizing reasonable precautions to prevent complications, by the practicing physician then the United States will have an epidemic. To thwart this the public health officials will resort to mass vaccinations of everyone, as the vital threat of real smallpox will exceed the complications of vaccinations.

In summary, multiple articles on the complications of smallpox vaccination are being written in the United States today because there isn't any smallpox. This can be attributed to our effective vaccination program but smallpox is still endemic in areas only one day away in the Jet Age.

Edward F. Crippen, M.D.
Deputy Health Commissioner
Community Health Services
City of Detroit

KALAMAZOO CLERGY JOIN DOCTORS FOR PROGRAM

"Religion in Medicine" was the subject of a combined physician-clergymen meeting presented this fall by the Kalamazoo Academy of Medicine. The dinner-meeting was attended by about 200 persons, including 50 clergymen of various faiths. Guests were welcomed by Frederick Margolis, M.D., president of the Kalamazoo Academy of Medicine.

The featured speaker, the Rev. E. A. Vastyan, was introduced by Harold DePree, M.D. Rev. Vastyan is assistant professor of humanities of the College of Medicine of the Pennsylvania State University.

Professor Vastyan called the surge of medicine "the revolution of our times" and stressed the need for religion to keep pace. The curriculum at Penn State is designed to offer religion an opportunity to become operative in the exciting arena of medical developments while offering medical students a chance to reinforce their human values, he said.

A lively discussion followed Professor Vastyan's talk. A five-member panel brought out some of the more practical problems and demonstrated the value of encouraging physician-clergy communications. Physician members of the panel were Richard Lemmer, M.D., and Thomas Reigel, M.D.

The Committee of Medicine and Religion of the Kalamazoo Academy has voiced support for the organization of a Pastoral Care Committee, composed of physicians and clergy.

Attorney General's Opinion Clarifies Drunk Driving Blood Testing

When a licensed nurse or a medical technician withdraws blood from a person for a chemical analysis for alcohol content, the presence of a licensed physician is *not necessary* provided appropriate directions have been given by him. This has recently been stated in Michigan Attorney General Opinion No. 4559. A copy of the opinion may be obtained by request to the Attorney General's office.

For several years there has been a cloud of doubt over the meaning of the law which states that persons other than licensed physicians may withdraw blood for this purpose under the physician's "direction."

MSMS has actively sought actual law change to clarify the position that, had the doctor's personal presence been intended, the term "supervision" would have been used. Because of the opinion stated above, no law change will be required.

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KEAST CITES THREE NEEDS OF UNIVERSITIES IN MEDICAL EDUCATION

Three "problem areas" for urban universities in the area of medical education and medical care were suggested by Wayne State University President William R. Keast in a recent address to the Economic Club of Detroit. He cited the need for:

Experimentation with methods by which education and practice in the human service professions — medicine, nursing, pharmacy, social work, law — can be more fully integrated.

Experimentation with new methods for delivering medical care and to discover ways to insure continuity of medical care.

Identifying environmental studies in engineering, medicine, and social science programs.

President Keast said he would like to see a reshaping of urban universities to meet critical urban problems and to accomplish for the city a transformation similar to that produced in American rural life and agricultural practice by the work of the land-grant institutions.

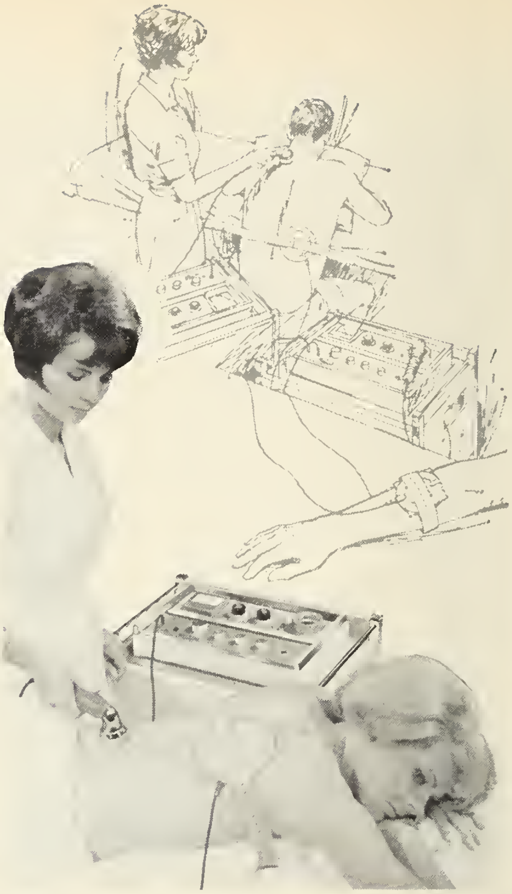
"IN DEALING WITH urban problems time is critical and society has chosen our materials for us. But we have found ways — in our medical and nursing schools — to deal with urgent human problems in an appropriate University manner, and there is no reason to suppose that other problems of urban society will not yield to imaginative and scrupulous professional effort."

President Keast suggested several goals for urban universities.

"THERE SHOULD BE greatly expanded educational opportunity in the urban institutions themselves. We now know that literally hundreds of young men and women from inner-city high schools and less advantaged suburban schools, not technically qualified for university admission, can, if they are given the proper encouragement and counseling while still in high school and before entering the university, and regular counseling and assistance after they enter, can meet the standards of a regular undergraduate course."

President Keast, said there are two objectives of the urban university which are of over-riding importance.

"One is to extend educational opportunity to large numbers of young people to whom it is not now available," he said. "The other, to apply the talents and energies of the university to the solution of urban problems, not merely of the immediate urban area but in general."



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Say you saw it in Michigan Medicine

Wanders from Assignment in HCR 88

Legislative Study Committee Considers "Healing Arts Advisory Committee" Idea

BY OTTO K. ENGELKE, M.D., CHAIRMAN
MSMS LEGAL AFFAIRS COMMITTEE

Faced with more and more proposals each year by various health-related groups to augment their legal practice privileges, the State Legislature adopted a resolution in 1967 authorizing a study of "the area of responsibility of the various 'healing arts' and paramedical fields."

Singled out as examples for study in the resolution were osteopathy, chiropractic, optometric, podiatric and medicine, among many others. A joint Senate-House special committee was established with a maximum budget of $5,000 to review the various licensure and practice acts.

THIS LEGISLATIVE RESOLUTION (House Concurrent Resolution No. 88) very specifically stated that practice privileges should be related to the quality and quantity of education of the "various medical professions and related disciplines."

It suggested that in any up-dating of licensure laws the licensees should be permitted to do everything they were properly trained to do.

Any provisions should be eliminated from such laws however, which permit licensees to engage in practices for which they are not properly trained.

An example of the latter is language in the chiropractic licensure act which, in permitting chiropractors to adjust the spine by hand, also permits "the procedure preparatory to" (actual statute language) the adjustment, and adjustment of "surrounding bones and tissues" with respect to the spine (also actual language in the law).

HCR 88 flatly calls for a review of the implications of such loose-leaf language. However, the legislative committee established by the resolution seems to be indicating that it is on an entirely different — and unrelated — tack.

Since the end of the regular legislative session in August (presently a special session is underway, considering only those measures designated by the Governor) this committee has held one meeting. In the City-County Building, Detroit on September 14 a hearing was held and attended by representatives of practically all licensed "healing arts" groups in Michigan.

NO REFERENCE WAS made by the committee to a review of the present laws in the light of the educational qualifications of the licensees. Instead, the committee asked for reactions to a proposal made by one of its members that a "healing arts advisory committee" be established. Presumably such a committee would be composed of representatives of the various licensed groups, and it was suggested that "certain" health legislative proposals could be referred to this advisory body for an opinion as to whether or not it should be adopted into law.

The legislative committee was not ready to suggest who would appoint the advisory group, how many members of each "healing art" would comprise it, to which types of bills the advisors would be referred, how the advisors would report or to whom, or any number of difficult related procedural questions. Instead, after general discussion each group was asked to submit its views to the legislative committee chairman (Rep. Blair Woodman, (R) Owosso) in writing.

MSMS, in a documented four-page communication to Mr. Woodman, has suggested that inasmuch as eleven of the fourteen health groups present at the Detroit meeting are active participating members of the Michigan Health Council, he ask the Council to explore the feasibility of creating any such "advisory committee." MSMS pointed out that the Michigan Health Council is established for the purpose of coordinating the efforts of various health groups, is non-profit, non-partisan, citizen-oriented, readily available, and officially recognized by State Government.

NO FURTHER MEETING of the legislative committee has been announced, nor has MSMS yet heard whether its suggestion is favorably viewed. The "healing arts advisory committee" idea poses literally dozens of complicated questions, each of which are directly related to the degree of value such a body might have to the legislature. Furthermore, HCR 88, adopted by both houses of the legislature, calls for something entirely different.

"Healing arts advisory committees" aside, a careful review of many of the provisions in already-existing practice arts — such as the ones cited in the chiropractic law — is already woefully overdue.

HCR 88 suggests that when health practitioners petition the legislature for privileges to perform certain acts on human beings, the petition be considered in the light of the caliber and extent of the petitioner's legitimate education. HCR 88 points a way by authorizing the legislative committee to employ technical and professional assistance, and to appoint advisors to aid in its study.

A REVIEW OF THE several practice arts cannot be conducted overnight, nor can it be accomplished in four or five sessions, but it can be done. Furthermore, it should be done before paramedical licensure laws are altered. By adopting HCR 88 the Michigan Legislature seems to have agreed that this is so.

The next move is up to the joint Senate-House committee — and it should not be made hastily.

Moral Responsibilities Of the Scientist Are Grave — Says DeBakey

Man must preserve the humane approach to science.

That was one of the contentions voiced by Michael DeBakey, M.D., nationally-known surgeon, at the recent University of Michigan's "Voices of Civilization Conference."

Doctor DeBakey declared "Man will undoubtedly be able one day to produce future generations of human beings with preselected biologic characteristics," he said. "He must somehow attain the wisdom and discretion to guide him in the proper use of this formidable power. Above all, he must preserve a humane approach to science."

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C. T. Ekelund, M.D., Dies; Was Former Secretary of MSMS

Clifford T. Ekelund, M.D., Pontiac surgeon recently honored by the Michigan State Medical Society and many appreciative patients, died October 22. He was 74.

A dinner in honor of the distinguished doctor was attended by more than 600 people. Robert J. Mason, M.D., Chairman of the MSMS Council, presented Doctor Ekelund with a citation in recognition of his many services to MSMS and medicine. President of the Oakland County Medical Society in 1935, he continued active in his county society. In 1936 he served as secretary to MSMS and was a leading organizer of Michigan Medical Services.

Born in Minneapolis, he was graduated from the University of Minnesota Medical School in 1918. During World War I he served at Base Hospital No. 26 AEF in France.

He was chief of staff of Pontiac General Hospital. Doctor Ekelund was also active in community affairs as a member of the Chamber of Commerce, a past president of the Rotary Club, and Senior Warden of All Saints Episcopal Church.

He was a Fellow, American College of Surgeons. His medical fraternity was Nu Sigma Nu.

G. W. Benson, M.D., Escanaba

Gilbert Wilfred Benson, a longtime general practitioner in Escanaba, died October 4. He was 64.

Doctor Benson, who was born in Hammond, Indiana, had practiced in Escanaba for about 30 years.

He had been a patient at St. Francis Hospital, Escanaba, for the past nine months.

A. J. Boyle, M.D., Detroit

Albert J. Boyle, Associate Professor of Internal Medicine and Professor of Chemistry, Wayne State University, died September 12 at the age of 57.

Doctor Boyle received his B.S. degree from Battle Creek College, his Ph.D. from the University of Michigan in 1938, and his M.D. from Wayne State University Medical School in 1945.

During World War II he served as a lieutenant in the Medical Corps and Senior Assistant Scientist in the National Institute of Health MSPHS.

He was associated with Providence Hospital and Receiving Hospital, Detroit, and was a member of Alpha Omega Alpha and Phi Beta Pi medica fraternities.

Howard O. Brush, M.D., Port Huron

Howard O. Brush, M.D., Port Huron physician for 42 years, died October 5. He was 75.

Born in Amhersberg, Ontario, Doctor Brush was graduated from the Detroit College of Medicine and Surgery in 1920. He did his postgraduate work at the Chicago Lying-In Hospital and in Pech, Hungary.

He practiced in Port Huron from 1920 until his retirement in 1962. He was on the staff of the Port Huron Hospital and was an honorary member of the Michigan State Hospital Society. He was a Life Member of the Michigan State Medical Society.

Doctor Brush was a past president of the Port Huron Rotary Club and served as vestryman of Grace Episcopal Church for 37 years.

James G. Carr, M.D., Detroit

James G. Carr, 75-year-old Detroit general practitioner, died October 29.

A native of Detroit, Doctor Carr was a graduate of the Wayne State University School of Medicine. During World War I he served as a major. He was a staff member of the East Side General Hospital and the U.S. Public Health Service Hospital.

Doctor Carr was a Life Member of the Michigan State Medical Society.

T. F. Clifford, M.D., Owosso

Thomas F. Clifford, M.D., died in Owosso October 2 at the age of 79.

A native of Detroit, Doctor Clifford was graduated from the Detroit College of Medicine. He practiced for many years in Detroit as an eye, ear, nose and throat specialist before moving to Owosso in 1965. Doctor Clifford was a Life Member of the Michigan State Medical Society.

T. S. Davies, M.D., Grosse Pointe

Thomas S. Davies, M.D., deputy director of the Grosse Pointe branch of the Wayne County Health Department, died October 16. He was 84.

Doctor Davies received a degree in mechanical engineering from the University of Michigan in 1907 and worked in engineering for several years before enrolling in the Detroit College of Medicine. After receiving his medical degree in 1919, he entered private practice in Detroit.

He joined the staffs of Herman Kiefer and Children's Hospitals and was in charge of three children's clinics for the Detroit Board of Health. In 1933 Doctor Davies became affiliated with the Grosse Pointe and Harper Woods health depart-

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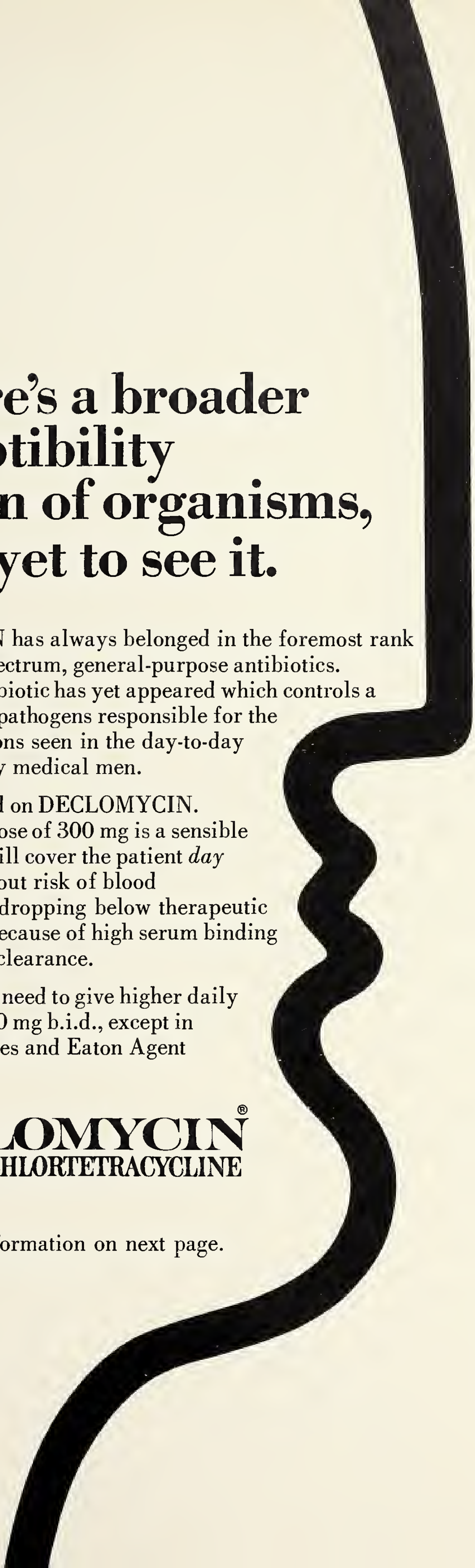

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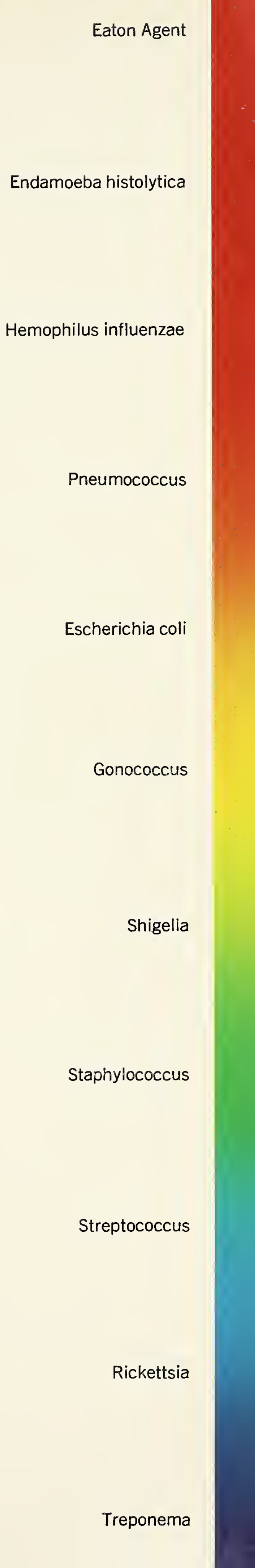
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Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

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ts. In 1943 he was named health officer for e communities.

member of Nu Sigma Nu medical fraternity, tor Davies was a Life Member of MSMS.

B. L. Franklin, M.D., Remus

enjamin L. Franklin, M.D., Remus, died Octo- 16 after practicing medicine for 68 years. At he was one of Michigan's oldest practicing sicians.

orn in Springfield, Ontario, Canada, Doctor nklin was graduated from the Saginaw Valley dical College in 1899 at the age of 21. He then ered practice with his father, also an M.D., at rrill, Michigan. In 1904 he moved to Mill- ok, near Remus, where he owned and operated rug store in addition to his medical practice.

le moved to Remus in 1920 and served the a continuously from that time. In 1949 the nmunity honored Doctor Franklin in a special emony for his many years of service. A resolu- n of the Michigan State Senate passed in May, 9, also recognized him for 50 years of service.

octor Franklin was coroner and medical exam- r for Mecosta County for many years. For more n 30 years he was surgeon for the Pere Mar- tte and Chesapeake and Ohio Railways. He s a director of the Citizens State Bank, Big Rap- , and a life member of the Remus Masonic dge 472.

t one time president of the Mecosta-Osceola Medical Society, Doctor Franklin was a Life Member of the Michigan State Medical Society.

H. L. Johnson, M.D., Southfield

Homer L. Johnson, M.D., Southfield physician, died October 20 at the age of 68.

Doctor Johnson was on the staff of Henry Ford Hospital in Detroit for 38 years, having joined the staff after his graduation from the University of Iowa's school of medicine.

Vahram Kasabach, M.D., Detroit

Vahram Kasabach, M.D., chief of staff at Deaconess Hospital, Detroit, died October 10. He was 58. Doctor Kasabach received his medical degree from the University of Michigan Medical School in 1934. He was sponsor of the senior nursing class at Deaconess.

J. A. Maurer, M.D., Saginaw

John A. Maurer, M.D., Saginaw physician, died August 30 at the age of 64.

After many years as chief of the medical service for the chronic disease and rehabilitation center at Saginaw County Hospital, Doctor Maurer resigned and re-entered private practice in 1964.

He attended Alma College and, after graduation from the University of Michigan Medical School in 1927, he interned at St. Mary's Hospital in Saginaw. During World War II he served in the Army Air Force.

His medical fraternity was Theta Kappa Psi.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published Semi-monthly, Tri-monthly in November and December, 26 issues, mailed at Lansing, Michigan in Ingham County for December 1, 1967.

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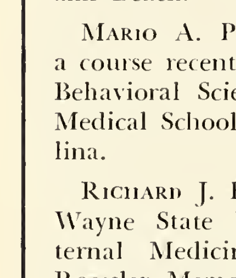

about doctors and their friends

Harold C. Mack, m.d., Detroit, has been appointed to the Council of Resident Education of the American College of Obstetricians and Gynecologists.

Merlin C. Townley, m.d., Detroit, has been selected as President of The Michigan Association of Neuropsychiatric Hospital and Clinic Physicians and Paul Lowinger, m.d., Detroit, has been selected as Secretary-Treasurer during the annual meeting at Caro, Michigan on October 12, 1967. Dr. Townley is Director of Department of Female Psychiatry at Wayne County General Hospital and Clinical Instructor of Psychiatry at Wayne State University.

Myron E. Wegman, m.d., Dean of the U-M School of Public Health and professor of pediatrics in the Medical School, received one of the three 1967 Bronfman Prizes for pioneering health achievement. The $5,000 award, one of the nation's highest public health honors, was presented to Doctor Wegman by the American Public Health Association at a meeting in Miami Beach.

Mario A. Petrini, m.d., Detroit, conducted a course recently on "Human Sexuality" at the Behavioral Science Institute at Bowman Gray Medical School in Winston-Salem, North Carolina.

Richard J. Bing, m.d., Detroit, Chairman of Wayne State University's Department of Internal Medicine, delivered the Fifth Hugo Roessler Memorial Lecture on November 8 at the Temple University School of Medicine.

Frank M. Steele, m.d., has been named director of medical education at Borgess Hospital in Kalamazoo. Formerly Doctor Steele was at the Northwestern University Medical School where he specialized in infectious disease and clinical immunology.

Donald J. Birmingham, m.d., Detroit, recently spoke at two medical meetings, the Michigan Industrial Medical Association's annual meeting and the Michigan Industrial Hygiene Conference of the Michigan Industrial Hygiene Society. At the MIMA meeting his talk was on "Some Unusual Medicolegal Cases in Occupational Dermatology," and at the Conference he spoke on "Skin Hygiene to Prevent Dermatitis in Industry."

Richard C. Bates, m.d., was honored by the Lansing Employ the Handicapped Committee in its commemoration of National Employ the Handicapped Week when he was named "physician of the year." Doctor Bates heads the Alcoholism Clinic at Edward W. Sparrow Hospital in Lansing.

Richard N. (Dick) Philleo, who served as field secretary and legislative agent for the Michigan State Medical Society for five years, has joined the staff of the Michigan Real Estate Association in Lansing as legislative counsel. He had been on the staff of the American Medical Association in Chicago and Washington since 1961.

Johan Eliot, m.d., of the Center for Population Planning, Ann Arbor, was elected to the national board of the Planned Parenthood Federation of America at the federation's annual meeting in New York.

Elmer R. Jennings, m.d., native of Detroit and formerly professor of clinical pathology at Wayne State University, is the recipient of the 1967 John Elliott Memorial Award of the American Association of Blood Banks. The award, a scroll and $500, were presented to Doctor Jennings for "improvement of Blood Banking Standards" and "for his many contributions to the Association, especially for his long and continuing endeavors on behalf of major improvements in the Annual Program." Doctor Jennings now lives in Long Beach, California.

Robert P. Locey, m.d., Benton Harbor, is the new president of the Southwestern Michigan TB Detection Project. The organization, with a budget of $19,800, will conduct a program of tuberculin skin testing of school children and personnel.

Norman T. Samet, m.d., has been appointed as assistant medical director of the Haven Hospital and Psychiatric Center, Rochester, Michigan. Dr. Samet had been a staff member of the Haven for one year and prior to that was in private practice.

Michigan medicine

MICHIGAN MEDICINE
MICHIGAN STATE MEDICAL SOCIETY
VOLUME 66, NUMBER 26
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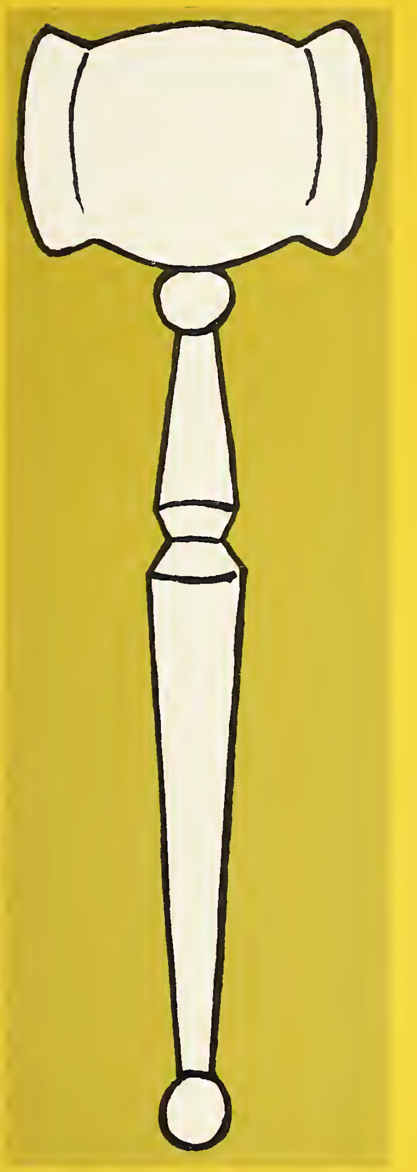

DIGEST OF PROCEEDINGS
1967 HOUSE OF DELEGATES

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1967 House of Delegates Proceedings
102nd Annual Session
Michigan State Medical Society

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Michigan State Medical Society
102nd Annual Session
September 24-26, 1967

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The One Hundred Second Annual Session of the House of Delegates of the Michigan State Medical Society, held at the Pantlind Hotel, Grand Rapids, Michigan, on September 24-25-26, 1967, convened at 8:15 p.m., James J. Lightbody, MD, Speaker of the House, and Louis F. Hayes, MD, Vice-Speaker of the House, presiding.

2. Report of Credentials Committee

Chairman K. T. McGunegle, MD, reported: "Mr. Speaker, there are 136 delegates seated, the majority of whom are not from any one county."

3. Invocation

The Speaker called upon Vice-Speaker Hayes to give the invocation.

4. Speaker's Remarks — J. J. Lightbody, MD

We are happy to welcome the student representatives of our three state medical schools. In addition, the deans of our three medical schools have been given special invitations to attend the House of Delegates meetings.

You may have noticed that there are some changes in the number and names of our reference committees this year. There have been many times in the past when several of our reference committees had no work assigned to them, while other reference committees were overburdened with resolutions and reports.

Our Bylaws state in relation to the number of reference committees: "The House of Delegates may have the following reference committees together with tellers and sergeant-at-arms." The important word there is "may," because this leaves the Speaker with considerable flexibility in relation to the number of reference committees.

(The following report of the Speaker was presented to the Delegates in printed form.)

This is a brief review of implementation of resolutions adopted by the 1966 House of Delegates.

Res. 1 — Support of Four-Year Medical School at Michigan State University. Resolution 1 supported a request to the State Board of Education that MSU be granted authority to expand its pre-clinical College of Human Medicine to a full college granting the degree of doctor of medicine.

This resolution was sent to the State Board of Education with letters urging approval of the MSU request by the Board. A letter and copy of the resolution also went to the Governor. Subsequently the Board granted permission to MSU for this proposed expansion.

Res. 2 — Support of Maximum Development of Wayne, U-M and MSU Medical Schools. Resolution 2 directed that the Legislature, as well as the Governor and his staff, be urged to provide sufficient funds for maximum development of medical education facilities at the three universities.

Copies of the resolution were sent to the State Board of Education, Michigan State University, the Chairman of the Citizens Committee on Education for Health Care, Governor Romney, and members of the House and Senate education and appropriations committees.

Res. 3 — Reinstatement of Partnership Billing by Blue Shield. This resolution was disapproved.

Res. 4 — Advance Presentation of Resolutions. The House took no action on this resolution.

Res. 5 — Medicine and Osteopathy. The House considered together Resolution 5 re dual education of MDs and osteopaths, Resolution 61 re hospital staffs and osteopaths, and Resolution 63 re drafting osteopaths into military service. The House took no action on these resolutions but referred them to the Committee on Medicine and Osteopathy with a recommendation "that prudent efforts be made toward progress for the best medical care for the people of the State of Michigan." (See Annual Report of Committee on Medicine and Osteopathy.)

Res. 6 — Opposition to Compulsory Use of Generic Names of Drugs. As directed in Resolution 6, MSMS informed all Michigan members of the U.S. Congress, the Secretary of the Department of Health, Education and Welfare, and the Surgeon General of the United States of its opposition to proposed legislation requiring exclusive use of generic names of drugs, and urged their support of the MSMS position.

Res. 7 — Michigan Board of Pharmacy Rule re Pharmacist Review of Hospital Orders. Resolution 7 directed the Liaison Committee with the Michigan State Pharmaceutical Association to re-study this rule and report to The Council whether it should be rescinded or modified.

This Committee has not had a meeting as yet, but a copy of the resolution has been placed in the Committee's agenda file for consideration at its next meeting.

Res. 8 — Educational Campaign re Crime Prevention. Resolution 8 urged that AMA continue and expand its efforts in crime prevention by initiating educational programs for physicians and by appropriate studies of the medical aspects of crime prevention and urged MSMS and county medical societies to initiate similar educational programs on crime prevention.

The introducer of the resolution has been in continuing contact with the AMA and efforts are currently being made to define and develop the ingredients of a suitable educational campaign.

Res. 9 — Revision of PKU Law. Resolution 9 urged that MSMS seek revision in the PKU law so that the physician in charge of the care of the newborn be responsible for the PKU testing, rather than the delivering physician.

The Legal Affairs Committee reviewed this resolution and directed that MSMS support a bill in the current Legislature which would bring about this change. Subsequently this legislation was enacted by the 1967 Legislature.

Res. 10 — Statewide Policy on Telephone Listings by MDs. Resolution 10 directed that the Judicial Commission establish rules on telephone listings that would apply to all doctors of medicine in Michigan.

The Judicial Commission, after studying the matter, adopted the AMA Guidelines for Telephone Listings and transmitted them to component medical societies of MSMS for information.

Res. 11 — New Section on Thoracic Surgery. Resolution

11 asked that a new Section on Thoracic Surgery be established. The reference committee presented proposed Bylaws changes to create such a section and these were laid over until the next regular meeting of the House in 1967, in accordance with MSMS Bylaws provisions. (See Annual Report of Committee on Constitution and Bylaws.)

Res. 12 — Support of Drug Industry. Resolution 12 reaffirmed MSMS support of the responsible leadership of the ethical drug industry. This evidence of MSMS support was transmitted to the Pharmaceutical Manufacturers Association.

Res. 13 — Opposition to Limitation of Doctor's Right to Dispense Medication. Resolution 13 opposed any limitation on the right of doctors to dispense medication to patients and noted the available services of county medical society ethics committees and the MSMS Judicial Commission in investigating any reported abuse of this right.

This resolution was transmitted to the MSMS Judicial Commission for its information and any appropriate action.

Res. 14 — Elimination of Income Levels and Fee Schedules from Blue Shield Policies. The House took no action on this resolution.

Res. 15 — Utilization of Medical Societies Committees for Medicare Complaints. Resolution 15 directed that on questions involving competency of physicians and quality of medical care all hospitals in Michigan, and Michigan Medical Service, be urged to utilize the services of appropriate committees of the local medical society.

The Council, upon recommendation of the Committee on Governmental Medical Care Programs, interpreted Resolution 15 to mean that "when a hospital or the fiscal carrier receives a complaint regarding competency or quality of medical care, the hospital and the fiscal carrier should refer the complainant to the local county medical society in which the physician holds membership."

Res. 16 — Definition of Customary, Prevailing and Reasonable Fee. Resolution 16 defined officially customary, prevailing and reasonable fees.

As directed in the resolution, this definition was transmitted to Michigan Medical Service as fiscal agent of the Medicare program in Michigan.

Res. 17 — Hospital Progress Notes Sufficient Evidence of Medical Necessity for Medicare. This resolution was not approved.

Res. 18 — Single Medical Practice Act. Resolutions 18 and 34, which requested legislation to declare medicine and osteopathy one and the same profession and to establish a single medical practice act, were not acted on by the House but were referred to the Committee on Medicine and Osteopathy with the recommendation that legal advice be obtained before the problem is presented to the Legislature.

The Legislature decided that this complicated and controversial subject was one that could not be considered until the 1968 Session. (See Annual Report of Legal Affairs Committee.)

Res. 19 — Dues Increase for Augmented Legislative, Governmental and Public Relations Program. This resolution was disapproved.

Res. 20 — Thanks to Woman's Auxiliary for Assisting Healthmobile Project. Resolution 20 expressed the thanks and appreciation of MSMS to the Woman's Auxiliary for its help in hosting the Healthmobile during its year-long tour throughout the state.

The resolution was communicated through articles in *Michigan Medicine* and *The Auxilium.*

Res. 21 — Commendation of Healthmobile. Resolution 21 commended the work of all those who helped in the Healthmobile project and outlined in a brief resume its statewide, year-long tour.

Res. 22 — Definition of a Specialist. Resolution 22 defined a specialist for use in connection with Title XVI and Title XIX of Public Law 89-97.

The Council during the year met with representativ of two component medical societies, who advocated th rescinding of this resolution. As a result of the questio raised re the necessity of designating specialists by th Medicare carrier, The Council appointed an ad hoc com mittee to study the entire matter.

The committee concluded that the HEW did requi specialty designation and that the most fair and reaso able criteria can and properly should be made by phys cians.

The Council adopted this report, reaffirmed its beli that the 1966 House of Delegates Definition of a Specia ist is a practical and reasonable one, and authoriz greater dissemination of this information.

Res. 23 — Concept of Fair and Reasonable Fees. Th House took no action on this resolution.

Res. 24 — Approval of Legislative Review of "Healin Arts" Licensure and Practice Laws. Resolution 24 urge the Legislature to review existing licensing and practic acts for all paramedical fields, in the implementation o House Concurrent Resolution 296, and commended th Legislature for its actions to insure quality health car

The Legislature has agreed to study in depth the hea ing arts and paramedical fields. For details on this sub ject, see Annual Report of the Legal Affairs Committe

Res. 25 — Proposed Changes in House of Delegate Meetings. Resolution 25 which urged separation of th House of Delegates meeting from the fall Scientific Ses sion, and Resolution 27 which urged a change in dat from fall to late winter or early spring, were considere together by the reference committee. The reference com mittee recommended adoption of a substitute resolutio urging that the House meeting be scheduled in March o April of each year. However, the House did not adopt th substitute resolution but instead referred the substitut resolution and the original Resolutions 25 and 27 to th House of Delegates Committee to Study Procedures o the House of Delegates for report at the 1967 annua meeting. (See Report of House of Delegates Committee t Study Procedures.)

Res. 26 — Equitable Payment of Physicians in Blu Shield Insurance. Resolution 26 requested that the Blu Shield Board of Directors "resolutely study the equitabl payment of all members of the physician team."

This resolution was transmitted by letter to Michigan Medical Service.

Res. 27. This resolution was considered with Resolution 25 (see above).

Res. 28 — Hospital-Based Specialists. The House took no action on this resolution.

Res. 29 — Concept of "Usual and Customary Fees." Resolution 29 directed that The Council communicate the concept "that physicians' and surgeons' 'usual and customary fees' be recognized as flexible in nature and variable from time to time" to the appropriate governmental units.

This has been implemented on a continuing basis by the Committee on Governmental Medical Care Programs.

Res. 30 — Medicare Fees. The House took no action on this resolution.

Res. 31 — Committee re Medical School Expansion. Resolution 31 called for the appointment of a committee including legislators, medical educators and doctors of medicine "to provide continuing pressure for medical school expansion."

MD representatives of the committee have been selected and invited to serve.

Res. 32 — Expansion of MSU College of Human Medicine. The House took no action on this resolution.

Res. 33 — Legislation re Implied Consent to Blood Al-

cohol and Other Tests. Resolution 33 directed that MSMS encourage the enactment of legislation making compulsory the determination of blood alcohol, or the use of approved breathing tests on drivers suspected of having sufficient alcohol to impair their driving, under an Implied Consent Law.

This resolution was referred to the Legal Affairs Committee for implementation. Subsequently the Legislature enacted an implied consent law which, while it makes provision for the blood test for intoxication, emphasizes the use of the breath test. This law was endorsed by the Society and contained language offered by MSMS.

Res. 34. This resolution was considered with Resolution 18 (see above).

Res. 35 — Implementation of Michigan Relative Value Study. Resolution 35 directed that Michigan Medical Service be advised that MSMS desires that the current Michigan RVS be used in description and coding of services.

This resolution was transmitted by letter to Michigan Medical Service.

Res. 36 — Use of RVS as a Guideline for Payments in Michigan Medical Service Contracts. Resolution 36 directed that all new Michigan Medical Service contracts use the current Michigan RVS with an appropriate conversion factor as a guideline for payments, paying each physician his usual, customary and reasonable fee for services rendered.

This resolution was transmitted by letter to Michigan Medical Service.

Res. 37 — Payment to Specialists Under M-75. The House took no action on this resolution.

Res. 38 — Heart-Cancer-Stroke Program. Resolution 38 directed that MSMS exert its leadership to assure that implementation of Public Law 89-239 be directed to the education of physicians and not involve patient care, and commended the medical school deans for their implementation of the planning phase of this program.

This letter was transmitted to the MSMS representative to the Michigan Association of Regional Medical Programs for his use in stating the MSMS view to the Board of the Association.

Res. 39 — Nursing Wage Scale. Resolution 39 called for appointment of a committee to help establish fair compensation standards for nursing personnel. The House adopted the resolution and referred it to the Committee on Nursing for consideration and appropriate action.

The Committee on Nursing transmitted this resolution to the Liaison Committee of the Michigan Nurses Association and the Michigan Hospital Association, and to the Economic Security Committee of the MNA, for their information.

Res. 40 — Rescinding the Conversion Factor for the Michigan Relative Value Study. This resolution was disapproved by the House.

Res. 41 — Change of Requirements for Certified Income Status of Policyholders of Michigan Medical Service. Resolution 41 requested Michigan Medical Service to classify any policy held by other than the major breadwinner in a household/family as non-certified.

This resolution was transmitted by letter to Michigan Medical Service.

Res. 42 — Change in Law re Disposition of Personal Property of Deceased by Medical Examiner. Resolution 42 asked that legislation be introduced to amend the medical examiner law to provide that guardianship of such properties of the deceased as the medical examiner deems necessary shall be retained by him.

This resolution was transmitted to the Legal Affairs Committee for implementation.

Res. 43 — Waiver of Physician-Patient Privilege in Personal Injury Suits. Resolution 43 reaffirmed MSMS opposition to any change in court rules or in the statute to waive the physician-patient privilege when lawsuit is initiated.

As directed in the resolution, this action was transmitted by letter to the State Bar of Michigan.

Res. 44 — Discrepancy Between MMS and Medicare Fees. The House took no action on this resolution.

Res. 45 — Hospital Utilization Review. The House took no action on this resolution.

Res. 46 — Driving License Evaluation and Examination. Resolution 46 urged that the MSMS Committee on Highway Accident Prevention direct its effort toward legislation to accomplish driver examination and re-evaluation when a physician finds it is indicated, and that doctors be required to report drivers who have a disease or infirmity which is a driving hazard.

The House took no action on the resolution but referred it to the Committee on Highway Accident Prevention. The Committee subsequently presented to The Council a recommendation that The Council seek to establish a Medical Advisory Board to the Michigan Secretary of State on evaluation of driving licenses for those with physical and mental handicaps. The Council approved the recommendation in principle and requested the Committee to proceed with a proposed preliminary meeting and report back to The Council with proposed guidelines to describe the role and duties of such a medical advisory board.

Res. 47 — AMA Activity to Seek National Legislation to Improve Medicare. Resolution 47 asked that AMA be requested to promote constructive legislation improving existing government health plans and continue to offer constructive advice.

The AMA has introduced legislation to make constructive amendments in the Medicare law, and is continuing to do so.

Res. 48 — Nominations for the Judicial Commission. This resolution was not approved.

Res. 49 — Appropriation of State Funds for the Treatment of Alcoholism. Resolution 49 directed the Legal Affairs Committee to urge the Legislature to appropriate adequate funds for the care and treatment of alcoholics.

The MSMS Alcoholism and Drug Addiction Committee and the Mental Health Committee met with the Chairman of the Legal Affairs Committee to discuss this resolution, and subsequently MSMS lent its support to the appropriation bill which provided the most adequate funds.

Res. 50 — Uniform Drug Identification. Resolution 50 called for MSMS endorsement of generic or trade name labelling of drugs. While the House did not approve the resolution, it agreed with the intent and recommended that the MSMS Liaison Committee with the Michigan State Pharmaceutical Association, for the best interests and safety of all concerned, explore some method of uniform drug identification, and that the Committee's report be reviewed by The Council for implementation if needed.

This Committee has not met as yet; however, this instruction of the House has been placed in the Committee's agenda file for consideration at its next meeting.

Res. 51 — Status of Externes. Resolution 51, which called for encouragement of enactment of legislation to promote the externe concept of clinical training, and provide necessary legal protection, was not approved by the House, but the House referred it to the Education Liaison Committee for study.

At the request of the Education Liaison Committee, MSMS Legal Counsel researched existing Michigan law and found that at present there is no legal protection for the externe. The Committee then referred Resolution 51 to the Legal Affairs Committee for its further consideration.

Res. 52 — Direct Billing by Hospital-Based Physicians. Resolution 52 reaffirmed the MSMS position re the right of hospital-based physicians to bill patients for services.

In discussion of the resolution, The Council noted that the House discussion on the resolution referred to anesthesiologists, pathologists, radiologists and physiatrists as hospital-based physicians, and did not include physicians in training.

Res. 53 — Qualifications of Members of Judicial Commission. This resolution was not approved.

Res. 54 — Support of Legislative Activities. Resolution 54, which called for a dues increase to finance legislative activity, with funds to be divided between AMPAC, MDPAC and the county unit of these organizations, was not approved because of the compulsory aspect of the raising of funds. However the House supported the concept of voluntary contributions through MDPAC and AMPAC and recommended continuance of the present program of including a request for funds with the annual MSMS dues statement.

This request was included in the 1967 dues billing.

Res. 55 — Hospital Privileges for Licensed Physicians. Resolution 55 supported the principle that every ethical licensed physician have admitting and staff privileges commensurate with his training and skill in at least one accredited hospital.

In approving this resolution, the reference committee "freely admitted it was not capable of proposing methods by which this principle can be implemented, but did hope that the adoption of the resolution would serve as a catalytic agent in evoking action in the near future."

The introducer of the resolution has been requested to submit a guest editorial for *Michigan Medicine* on this subject.

Res. 56 — Commendation to Michigan Medical Service. Resolution 56 recognized the accomplishments of Michigan Medical Service and urged that Blue Shield continue its efforts to give the consumer good health care coverage.

Res. 57 — Rotating Membership on Judicial Commission Within District. Resolution 57 directed that the Judicial Commission study the possibility of the rotation of Judicial Commission members within districts.

Subsequently the Judicial Commission reported to the Speaker that it believed it impractical to inaugurate such a policy, although recognizing that the idea has merit. The Commission emphasized that the method for nominating candidates to the Judicial Commission was established to allow for district-oriented, rather than county-oriented, physicians. It also pointed out that the Judicial Commission is not a partisan political body and that geographic representation on the Commission merely insures statewide participation.

Res. 58 — Suture of Lacerations Billing by Blue Shield. This resolution was not approved.

Res. 59 — Establishment of House of Delegates Committee to Study Resolutions Adopted by Other State Medical Society Houses of Delegates. Resolution 59 directed the Speaker to appoint a Committee "to be assigned the responsibility of studying the feasibility of collecting and reviewing resolutions passed by other state houses of delegates with the intent that matters of importance to MSMS be reported to this House" and that the AMA be petitioned to establish a central agency where resolutions from other states would be available for study.

The Speaker appointed such a committee and the resolution was transmitted to the committee for implementation. (See Annual Report of House of Delegates Committee to Study Resolutions from Other States.)

Res. 60 — Acceptance of National Board of Medical Examiners Certifications. Resolution 60 called for suitable legislation amending the Michigan Medical Practice Act to enable the Michigan State Board of Registration in Medicine to accept the National Board examination as well as the present Michigan examination.

The Council referred this resolution to the MSMS Legal Affairs Committee for implementation. In 1967 the Legislature did enact such legislation. (See Annual Repor of Legal Affairs Committee).

Res. 61. The House considered this resolution with Resolutions 5 and 63 (see Res. 5).

Res. 62 — Repeal of Basic Science Law. Resolution 62 called for legislation to repeal the Basic Science Law. This legislation was introduced in the 1967 Michigan Legislature, but failed to pass. (See Annual Report of the Legal Affairs Committee.)

Res. 63. The House considered this resolution with Resolutions 5 and 61 (see Res. 5).

Res. 64 — Michigan Employment Security Commission Amendment. Resolution 64 called for MSMS to oppose inclusion of small businessmen and professional people as contributors to the MESC fund.

After conferring with the introducer of the resolution, the Legal Affairs Committee felt that no practical action could be taken at this time.

Res. 65 — Commendation to MAP for Formula Television Series. Resolution 65 gave official MSMS commendation to MAP for this television series.

This action of the House was officially reported by President Payne at the 1967 MAP Congress of the Professions.

Res. 66 — Alcoholism as a Disease Entity in Michigan Medical Service Fee Schedule. Resolution 66 called for MSMS and MMS recognition of alcoholism as a disease entity and for MMS inclusion in its fee schedule of payment for its care and treatment. The House referred the resolution to the Committee on Mental Health for an opinion. (See Annual Report of Committee on Mental Health.)

Res. 67 — Storm Door Injuries. This resolution was disapproved.

Res. 68 — Publicity Regarding Administrative Costs of Medicare. Resolution 68 called for publicity from Michigan Medical Service and MSMS to doctors of medicine and all citizens of Michigan regarding the administrative costs involved in the Medicare program.

In response to the MSMS request for such information, Michigan Medical Service replied that the guidelines from the Social Security Administration for the program did not permit the fiscal intermediary to release such information, since this information "is considered to be the reporting responsibility of the Federal Government."

Res. 69 — Composition of the Advisory Committee to the Executive Director. This resolution was not approved.

Res. 70 — Delegates Participation in MDPAC. Resolution 70 commended the MDPAC organization and recommended that MSMS Delegates set the example for financial support by contributing on an individual basis to MDPAC.

This action of the House of Delegates was transmitted to all seated delegates by the Speaker. The text of the letter appeared in *Michigan Medicine.*

Res. 71 — Practicing Physician Representation on AMA Education Committees. Resolution 71 urged the AMA to continue its practice of appointing representatives of the private practice of medicine on all of its committees relating to medical education. This House action was transmitted to the AMA by letter.

Res. 72 — Recognition of U-M Medical School Sesquicentennial. Resolution 72 directed that an award be presented publicly by the MSMS President to the U-M Medical School for its valued service over the years and that the U-M sesquicentennial be brought to the attention of the AMA House of Delegates.

In June, 1967, the AMA adopted a resolution to recognize the U-M sesquicentennial. The MSMS President will present a suitable award at the Medical Center Alumni Association meeting in October. U-M Vice-President Niehuss will receive the award for the University.

Res. 73 — Payment to Chiropractors Under Medicare. Resolution 73 voiced strong MSMS opposition to any provision in the Medicare law to provide for payments to chiropractors.

Res. 74 — MSMS Leadership Responsibilities. This resolution was disapproved.

Res. 75 — Introduction of Resolutions. The House took no action on this resolution.

Res. 76 — Workshop for Delegates. Resolution 76 requested that a Delegates Workshop be developed for the purpose of communication of Society business at the district level.

The Annual Delegates Workshop has been scheduled for Sunday, September 24, 1967, in Grand Rapids.

Res. 77 — Honorary Membership for General Counsel Lester P. Dodd. Resolution 77 conferred honorary MSMS membership on Mr. Dodd for his long and invaluable service to MSMS. This resolution was adopted by a rising vote of the House and Mr. Dodd was presented with an engraved gold membership card as a memento of the occasion.

Res. 78 — Commendation to Sidney Adler, MD, Retiring President of MMS. Resolution 78 officially recognized Doctor Adler's six years of service as MMS President. This action of the House was transmitted officially by letter to Doctor Adler.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended acceptance of the complete and concise report.

THE HOUSE adopted the report of the Reference Committee.

5. Remarks of American Medical Association President-Elect Dwight L. Wilbur, MD

Doctor Wilbur discussed "The Physician and Health Manpower." Following are extracts of his remarks.

Let's consider for a moment the matter of the shortage of physicians. How many physicians do we need in this country? Nobody knows. The medical students who enter medical school today will really not be prepared to practice for ten years. Who knows, at that time, how many psychiatrists we will need, or how many radiologists, or how many family physicians. Who knows where they should be in the way of geographic distribution. Who knows what changes there will be in the diseases that will need to be treated, and the methods of treatment which will be available at that time. Who knows of the potentialities of automation, and who knows what will be the alterations in the organization and distribution of medical care.

Since these are really all unknowns, we must say that at the present time (and, I suspect, for all time) we will really not know what the optimal number of physicians' services will be, because again the demands of the patient and the needs of the patient may be quite different. So, the matter of actually quantitative manpower cannot be done satisfactorily, either to us or economists or sociologists or other experts in this field. But we do all recognize that there is a shortage; and the shortage must be overcome to as great a degree as possible, certainly, in the next five to ten years.

The next problem that I think is important has to do with the matter of the inter-relationships of those who are on the health team. This is where you gentlemen are going to play such an important role.

One figure that keeps recurring is that by 1975 there will be ten individuals in the health field for every physician. I think we should ask ourselves: What are these people going to do? First of all, who are they? They are dentists, nurses, pharmacists, all sorts of technicians, all sorts of therapists, medical secretaries, medical record librarians, social workers, and the like. They are categorized into 78 or 100 different categories depending on which method you choose to use.

Who is going to organize these individuals, and who is going to direct their activities so that they will constitute another commonly used term, the health team?

Now a few words about what we have been able to do with this term, "health team."

Frankly, we have not been able to define it as yet in our AMA Committee, although we have been dealing with it for about a year now. But there are certain concepts in respect to the health team that I would like to observe.

The best that we have been able to do so far in defining it is in these terms:

A health team is a group of persons having professional and technical skills directly connected with the total health of an individual: Diagnosis, treatment, prevention and research into the cause and treatment of disease, and rehabilitation of the patient.

The services required of the health team are principally these: Physicians and dental services (and keep in mind I am speaking of services now), nursing services, technical diagnostic services, pharmaceutical services, administrative services, and community and social services.

All of these services are considered essential by the Committee in the total health care program. Although the number of persons involved and the degree of their professional or technical skills required will vary considerably from patient to patient in caring for a minor illness, for example, all of the essential services required may be rendered by the physician alone. In the care of a patient requiring, say, an open-heart operation, several physicians with special technical skills and a score or more of individuals with special technical skills may be required.

What the health team will consist of five or ten years from now, and how it will function, will have to be determined; but in large part it will depend on how we organize the health team. Let me indicate how complicated this is going to be, because such a team, which may consist, as I have said, of a single physician or many individuals, is going to have to deal with patients under varying circumstances, in acute illness, in chronic illness, in the hospital, in the extended-care facility, in the physician's office, or in the patient's home, in settings of group practice, in rural and urban settings, for the desperately ill patient, for the injured, for the hypochondriac, and for the mentally ill.

So, the boundaries are not too distinct and wide, and I think you can immediately see what a complicated problem this is. But all the time over us hangs the stimulus from the Government to do it ourselves or it will be done for us. This is what leads me to bring this matter to your attention this evening.

Finally, what about the organization and distribution of health care? To those of us who have practiced for years, the present method of organization in private practice, I think, seems quite satisfactory in most respects.

And yet I must recognize that if the Government is going to get involved more and more economically than it has, the chances are pretty good that for this reason and for the social changes that are occurring there are going to be significant modifications.

If new means of delivery of health care are going to be developed, who is going to develop them, and how are we going to help in leadership in developing them?

I think to a considerable extent what happens depends on us. I think it depends on us more than we think it depends on us. These are the challenges facing the profession.

6. President's Address — C. Allen Payne, MD

The main purpose of the address of the President is to bring to you his report of the activities of the Society in the year past, his estimation of the condition or status of the Society, and his impressions of what is needed in the future, both near-term and long-range, to make our organization even stronger and more effective. Today and tomorrow you will be hearing from others concerning the progress that has been made in various organizational and financial matters in order to prepare our Society to better cope with the many challenges facing organized medicine today and in the future.

I would agree that our Society is in a sound financial state and has made significant progress in becoming more effective in health affairs throughout the State. However, I should like to mention some activities which in my opinion may not be stressed enough in these other reports.

During the past year the officers and members of The Council have initiated projects and developed methods to further improve reciprocal communications among medical society leaders, individual members of MSMS, and the Society headquarters. These projects include three which I feel are most important:

1 — Regional CPCs. There were six regional conferences of county medical society leaders and committee chairmen with officers and members of The Council of MSMS to discuss common professional concerns, the various activities of MSMS and the challenges and problems that are facing organized medicine at both the county and individual physician level.

2 — In May of this year there was a one-day Informational Meeting for all county medical society leaders and all delegates and alternate delegates to MSMS. This was designed to brief these medical leaders on the problems facing medicine so that they might return to their constituents and make plans for desired action at the September meeting of the House of Delegates.

3 — Greater effort was made to develop more effective communications and closer liaison between MSMS and members of the State Legislature and other departments of State Government through conferences of MSMS officers with State officials and more effective advisory and liaison committee activity.

In my opinion the paramount need of our organization is a much greater and more effective participation of a larger number of MSMS members in the affairs and activities of the Society. Certainly a better informed leadership and motivated membership are the focal points from which greater activity will develop.

With this idea in mind, it is my strong recommendation that these projects, especially the first and second, be continued and further improved and refined, to the end that there will be even better reciprocal communication among county medical society leadership, every member of MSMS and the officers and members of The Council. The eyeball-to-eyeball confrontation afforded by such meetings is a most effective method of swapping important information, thus beginning the process of solving some of medicine's numerous problems.

There is no doubt that American medicine faces an increasing number of problems and challenges with each passing year. This has been called the most demanding era in our history, not only in medicine but in all facets of our national and international life.

Looking ahead at the entire field of health care, our thinking and our goals must be imaginative and dramatic, not commonplace nor complacent.

We no longer live in a frontier area, nor in a world of so-called rugged individualism, but at a time which requires cooperation, interdependency and a ready exchange of information and ideas. As applied to all phases of our nation's health program, this calls for a good share of imaginative leadership from the health professions, universities, and medical schools, hospitals, industry, labor, governmental agencies and the American public.

Many of our problems and challenges are the result of insistent demand for more health services, more physicians, more health personnel of all types, and more facilities for prevention, diagnosis, treatment, and rehabilitation of human ills.

I should like to briefly discuss some areas of major concern with the hope that you will take action to provide answers to these important problems and challenges.

1 — Government has become the largest and strongest single force in medicine in Michigan and throughout the United States. This is overwhelmingly so if medical education is considered part of government. Some of the more important governmental activities include Medicare, Medicaid, Heart, Cancer, Stroke, Comprehensive Health Planning, control and generic prescribing of drugs, mental health, and federal grants of various types.

To blindly thrash against the bonds that Government appears to be fashioning for the profession is not the answer. Quite the contrary, it has the effect of making the bonds stronger and tighter. The only way to maintain the freedom and dignity of medicine is to be better informed, more alert, and more unified than medicine's would-be captors. If the medical profession in its role as the major purveyor of health remains unified, flexible and active, it can call enough decisions so that it can preserve those freedoms of practice which are essential to its success and to its professional life.

2 — The number of legislative bills affecting the practice of medicine in Michigan is annually increasing in scope and number. The activities of MSMS in providing information and advice to the Legislature have also increased, yet we are having a hard time keeping pace with the accelerated tempo of legislation caused by Michigan's full-time Legislature. Attempts to regulate portions of the practice of medicine and attempts of other groups to legislate themselves into portions of the practice of medicine are of considerable concern to MSMS. There is need for constant readjustment of our activities in this area. Much time is required to uncover facts necessary to present to the Legislature and other influential persons and organizations. Increased action should begin at once.

3 — The relationship of physicians and MSMS to members of other medical and paramedical personnel and their organizations becomes increasingly complicated. It is important for us to attempt to better define and delineate relationships with the opticians and optometrists, and the podiatrists, psychologists, nurses and other paramedical groups before governmental regulation and regimentation of their activities drastically affects our patterns of practice.

4 — The self-evaluation and self-regulation of physicians through the development of principles and rules on ethics, discipline, professional qualifications and standards of conduct is the last line of defense of professionalism. The establishment of a Judicial Commission by MSMS as an independent judicial body to interpret the policies of MSMS and the ethics of medicine is a pioneering step. The necessarily expanded activity of this Commission requires the systematic exploration of many problems through legal, philosophical, religious and medical research plus opinion sampling.

5 — The application of new scientific discoveries and other medical advances to the private practice of medicine has in the past sometimes been the cause of difficulties in daily medical practice. Examples of such difficulties in the recent past are the sudden availability of polio and measles vaccines and the great public demand for their widespread use. The use of computers, automation, chemical and hospital engineering, and even new prepayment mechanisms are other recent developments which can affect the present methods of medical practice. You can be sure that the next decade will produce many additional scientific advances, and each will tend to further change our methods of practice.

With advanced knowledge of these developments, MSMS could prepare to make the most of these discoveries through increased service to the public and at the same time keep this service in conformance with professional policies. Using the know-how of our members, a system of pretesting scientific advances could be set up which would permit the profession to serve the public better and at the same time maintain its policies.

The problems I have presented are only representative of some of the more abrasive variety. Other more specific problems must include the constant need to improve the quality and distribution of medical care and to reduce its cost. Recently and repeatedly Secretary Gardner of the Department of Health, Education and Welfare has stated, "We cannot go on as we have in the past. New patterns (of health care) will be necessary. Those who entertain some apprehension as to what the new patterns will be had better plunge in and experiment with their own preferred solutions. Standing back and condemning the solutions that others devise won't stem the tide of change." And again he states: "Essentially the challenge is before the health professions. They must join the search for solutions. They must be willing to re-examine and overhaul long-established practices. The search for new and better and less expensive ways of doing things must be carried on by hospitals, medical schools, community agencies, and by the thousands of individual physicians serving the health needs of people."

The upshot of all this is simply that there is a wide diversity of problems involved in medical care and there is a complex of intricacies in each problem. It is apparent that there is no single answer, no single source for their solution. It is equally apparent that there are two things needed for the solution of all of them: 1 — Valid opinion. 2 — Valid facts.

Although many bits and pieces of research are being done by various groups and persons, there is no central collecting point outside of Government where this research is available. It is not available at all in easily assimilable form. It is not complete. It is not quickly available. It is not reliable nor up-to-date. It is not directed to medicine's needs.

If the medical profession is to maintain and improve its leadership in health affairs, it must proceed in an organized fashion to anticipate problems and prepare for their solution — and do so ahead of others. Neither the citizens of Michigan nor physicians need fear new decisions if MSMS policymakers have the authentic opinion of interested groups or qualified authorities, and the specific, applicable and reliable facts relating to the problem at hand. The danger which keeps Michigan medical leaders awake nights is that too little is known for sure about too many problems which require decisions from doctors who have had insufficient time to do personal research.

Whether this central collecting point for research information takes the form of an institute with bricks and mortar or is a bureau within our headquarters, or whether it is an integral part of MSMS or is an independent organization supported by funds from other organizations, are some of the policies that this House of Delegates should begin to determine during this annual meeting. Suffice it to say that I am convinced that there is great need for some methodology and mechanism perhaps somewhat separated from our Society to correlate and make available for review by decision-making bodies a vast and intricate mass of facts, factors and opinions affecting health care.

In concluding my remarks I must pay tribute to the work of our fine professional and clerical staff under the direction of Mr. Brenneman and Mr. Tryloff. I know of many instances where they have gone beyond the call of duty to carry out assignments important to the progress of our Society.

It has been a privilege and pleasure to work with the officers and members of The Council and to observe the long hours they devote to the activities of our Society and the furtherance of better health for the citizens of Michigan. Some problems have produced differences of opinion as to methods of solution, but in true democratic fashion in nearly all the cases the differences have been resolved and a united effort gained.

This leads me to my final comment, one which I made before but one which cannot be too often restated — UNITY. Organized medicine desperately needs greater unity if it is to maintain leadership and preserve freedom in the practice of medicine.

I sincerely thank you for the very enriching and very satisfying experience of serving as President of this great organization. I feel sure that under the leadership of the new officers and the members of The Council our Society will make additional progress in providing quality health care for all of the citizens of our State.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended that the remarks of the President be accepted.

THE HOUSE adopted the report of the Reference Committee.

7. President-Elect's Address — Bradley M. Harris, MD

Perhaps at this time we should say to ourselves: Where are we going? Or better, where should we be going? I find I sometimes become involved, as I know you do, with immediate programs and fail to project to what may lie ahead.

Let us assume that these primary factors determine adequate medical care. These are as pertinent today as they were when our Society was organized: Availability, competence and personalization.

With the implementation of Titles XVIII and XIX many changes in the patterns of delivery of medical care are inevitable. The problems inherent in the development of these programs have been largely foreseen by the medical profession and our apprehensions are well documented. Our efforts to be constructive in our approach have been frequently interpreted as obstructionist. We can afford to be oblivious to this intolerance as long as we continue to plan progressively and innovate intelligently, within the framework of existing legislation. We must always consider the possibility of seeking remedial reform through legislative channels as we document deficiencies in public health.

"Availability" is a relative term and a significant one. Exact definition is perhaps impossible. The present general excellence of our people's health in the State of Michigan attests to competence at this time. But is this enough?

There is an insistent demand for more health services, more physicians, more health personnel of all types, and more facilities for prevention, diagnosis, treatment and rehabilitation.

With all these demands for service, we are obviously in accord, and also deeply concerned that they be wisely utilized.

As we look ahead at medical care and research, the future must be constructed with the energy and daring that have built other aspects of our national economy. The dimensions of American medicine are deepening and widening, and we are relying more and more on various other fields of science, engineering and technology for help in developing the equipment and techniques needed.

As this scientific and technical process continues, we also have the complex task of making the benefits of new knowledge and skills as they apply to medicine readily available to every member of society as rapidly as possible. It becomes the personal responsibility of each of us to involve ourselves in these programs and thus assure our individual availability.

"Competence" may be viewed individually and collectively. Expansion of our efforts in the social and economic aspects of health care is fully as important and urgent as exploration into the mysteries of the cell or outer space. Whether we are thinking in terms of science or society, American medicine has never faced a greater array of challenges and problems than those that confront us today. If we are to cope with the existing and anticipated problems in the health care field, the medical profession must be prepared to seize the initiative and keep it. The one big, all-encompassing challenge is to do better — to become more competent.

At the American Society of Internal Medicine meeting in San Francisco last April, Dr. Phillip R. Lee, Assistant Secretary for Health and Scientific Affairs of the Department of Health, Education and Welfare, described the new National Center for Health Services Research and Development. He said: "The American Health Service system is about to undergo the same critical and hardheaded study that Ford or General Motors would give to a proposed new sports model. It will be a scientific, coordinated examination to spotlight defects and develop improvements."

I am convinced that the areas for improvement are limitless. We have barely approached the opportunities for automation in laboratory procedures and the application of computer techniques for the storage and coalition of clinical data.

However, I have some reservations that the so-called sophisticated techniques of "systems analysis" can be applied with any real meaning to personal medical care. The many aspects of treatment that involve so many human, personal and subjective factors belie such a premise.

It becomes apparent that it is imperative for the medical profession to establish effective research and development mechanisms of its own. We must assert ourselves and provide constructive action to solve whatever problems exist or develop. We must take the lead in shaping and planning our future.

We spend a great deal of time wrestling with the intricacies of Blue Shield and comparable insurance mechanisms. We must not permit this to usurp our interest in other phases of medical economics. The physical layout and operational patterns of our hospitals and offices can be improved and our efficiency will improve with them. Experimentation and innovation can lead to increased competence.

"Lack of personalization" in our care is the basis of most complaints today. With the increasing institutionalization of medical care in the future and the consequent need for the physician to deal more and more with governmental agencies, we as providers must not allow this depersonalization to occur. The people who practice medicine must determine the future of medical practice. We must be certain the patient senses constantly our warm, personal interest in him and all that affects his environment.

The concepts so essential to us in the practice of medicine are equally pertinent in the educational philosophy of all training programs.

Let us give our attention for a moment to the educational programs in Michigan. A fine spirit of cooperation exists among our three medical schools. This has resulted in the organization of the Michigan Association for Regional Medical Programs. Through this medium and extensions of it the medical schools will play an ever-greater part in determining medical practice patterns of the future.

We must continue to expand our services as practicing physicians to the students of these schools by providing them with information in the sociological aspects of medical practice as well as business routines.

There is also an opportunity to offer our professional services to community and other colleges in their rapidly developing programs of training in the paramedical fields.

Activities in this area will cost little and return big dividends in supplying helpers both technologically well trained and well oriented to good medical practice.

Individually we can all improve recruitment of more health personnel by more fully acquainting our local school counselors with the opportunities and rewards available in the paramedical fields.

I need not remind you of the many vacancies in the internship and residency training programs throughout the State. We have an opportunity and responsibility to extend our Society's services into the various recruitment programs with our hospitals.

I would be very remiss and not in character if I failed to compliment the fine work being done by our Journal, *Michigan Medicine*. Today it is functioning effectively and economically. Its quality is a source of challenge to other state medical societies. We should encourage the continuation and expansion of Medigram and other "hot news" programs which are now serving our membership. In addition, may I urge upon you the idea of a videotape library system headquartered in the MSMS offices at Lansing.

We as a profession tend to isolate ourselves even into our own social groups. With the expansion of governmental health care programs it becomes increasingly incumbent that we greatly extend our abilities into all community organizations — Chambers of Commerce, P.T.A.s, Community Chests, Scouts, to the end of educating our patients and learning their problems and fears. This has inestimable value in retaining and expanding our leadership in medical progress. With the knowledge acquired, we are better equipped to fulfill the local health needs and demands. In this regard I also recommend expansion of liaison meetings at the community level with all communication media representatives.

A growing interest among our membership in national and international affairs is apparent. This growth we must nurture. We must seek representation at all legislative levels that will adequately consider medicine's counsel in health-related legislation. Let us hope that the possibilities for world peace may be furthered through medicine.

I have cited only a few of the many emerging problems confronting us. Each problem can be an opportunity if we grasp it as it emerges. Within our State Medical Society I firmly believe that task forces directed toward accomplishing specific objectives should be developed. These groups would cut across the work of many of our committees and, by coordinating their work, permit us as a profession to make our contributions more effective. Certainly such task forces plus greater access to the findings of researchers in fields related to the distribution of health care can enhance our present programs.

In conclusion, by improving our availability, our competence and our personalization, we can fortify ourselves in meeting our grave responsibilities.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, conveyed its complete vote of confidence in Dr. Harris and pledged support of the policies outlined in his remarks.

THE HOUSE adopted the report of the Reference Committee.

8. Report of Woman's Auxiliary to MSMS — Mrs. Henry Scovill, President

It is a pleasure to come before you today. I welcome this opportunity to bring you greetings from the Woman's Auxiliary. You have assisted us in carrying out our Auxiliary program, helping us in many ways, and we sincerely hope that we have been able to make some worthwhile contributions to the Michigan State Medical Society. It is our hope that we can gear our Auxiliary program more closely to yours so as to coordinate our efforts with your objectives. Thus we can become more valuable to you and more effective in our communities.

Our theme this year, "Friendship Through Service," has taken on added meaning as the year has progressed. Our State officers and chairmen have worked toward making more effective inroads with the county auxiliaries and our relationship to them. This, we believe, has led to a better understanding and closer ties between the county and State auxiliaries and hopefully this has strengthened the link between county, State and national auxiliaries.

The year's activities began in October, with the National Conference held in Chicago, which provided materials and inspiration for a good send-off for district meetings. Our State officers and chairmen traveled around the State to these meetings, offering new ideas and support to the county auxiliaries.

This year we are proud and pleased to have District VII reactivated, and we were invited to start our tour with a delightful meeting in Traverse City. Our hope for the future is to make our district meetings more vital and meaningful to the county leaders throughout the State.

AMPAC representative and National Past President, Mrs. Ethel Gastineau, was our guest speaker for our Spring Conference in February. A highlight of the Conference was an informative talk by Dr. Tommy Evans and the showing of the film, "Parent To Child About Sex," an excellent film on a very timely problem. We feel very fortunate that this film, which now has won national acclaim, was produced by a Michigan doctor, Frederick Margolis, MD, with Mrs. Margolis, an Auxiliary member from Kalamazoo, as writer of the script.

A very important part of our Auxiliary work is our support of AMA-ERF. This year our combined auxiliaries contributed $23,406.78, an increase of $4,738 over last year. We are especially proud of Macomb County, who won the National Achievement Award for the largest AMA-ERF contribution per capita in its membership category. The award was presented at the national convention at Atlantic City.

Health Careers continues to play an important role in Auxiliary work. A total was reported of $16,152.92 offered by counties for scholarships, and 15,000 copies of *Horizons Unlimited* were distributed to schools and youth groups. It is significant that Health Careers Day was sponsored in two county areas in the Upper Peninsula with 350 attending. One county gave $900 for nursing scholarships and $3,117 for financial aid to any student pursuing a health career.

In the field of community services, the problem of venereal disease, and working with the schools, P.T.A.s, counselors and parents in health education, has captured the interest of many county auxiliaries. Also the Friendly Volunteer Service program has been taking hold and increasing in popularity as a community service project.

Each year we increase our efforts in World Medical Relief. Approximately 15,300 pounds of drugs were sent by our auxiliaries to World Medical Relief, along with many large pieces of equipment, books and journals.

In the field of mental health many Auxiliary volunteer hours have been spent in day care centers working with retarded and mentally disturbed children. Seclusion rooms at the Ypsilanti State Hospital have been remodeled and decorated, representing many volunteer hours spent by Auxiliary members.

Many Auxiliary members have been quick to respond to the requests of the Medical Society to help promote good legislation locally and nationally. Members have written to legislators and have promoted better understanding of issues in their local communities concerning good health legislation in the interest of organized medicine.

The active Woman's Auxiliary to Student American Medical Associations, which our State Auxiliary sponsors, is a continual inspiration to Auxiliary members who have the good fortune to work with the girls, our future doctors' wives. This surely is an important part of our Auxiliary program.

An important project for our State Auxiliary this year was the producing of fliers which were sent to every member in the State of Michigan. These attractive brochures of bright yellow and blue were designed to interest members in our coming convention and workshop. The printing of the fliers was made possible through the generosity of Michigan Blue Shield. Indications show that this promotion has sparked greater enthusiasm of members for our convention.

Because of requests coming from members, we are introducing workshops at our annual convention this year. These workshops are designed to aid county officers and chairmen in their auxiliaries, and to offer opportunity to share experiences with other Auxiliary members. Hopefully we will have a stimulating exchange of ideas, and many questions answered. We are fortunate to have Mrs. Karl Ritter, President of the Woman's Auxiliary to the American Medical Association, as a resource person at our workshop sessions. Her valuable contributions will add greatly to the success of this venture.

The accomplishments of the county auxiliaries are outstanding and very gratifying to all who have contributed so much toward these successes. At the same time we realize how much more could be accomplished if the nearly 3,000 eligible doctors' wives, not now members, would join our ranks. Doctors, we need your wives as members!

We all are aware that the complications of Government medical programs make it increasingly difficult for you doctors, our husbands, to give time to civic service. We know that the Medical Society of necessity is closely watching legislation in relationship with hospitals and other health facilities and necessarily limiting their time for direct contact with the general public. Therefore, physicians and medical societies are showing a growing interest in and recognition of the part our auxiliaries can play, thus encouraging the real potential of the Auxiliary as a liaison between the community and the medical profession.

I wish to thank the Michigan State Medical Society for all the courtesies and financial assistance given us in carrying out our program this year. I sincerely appreciate the invaluable help of Mrs. Marjorie Karker, liaison between the Michigan State Medical Society and the Woman's Auxiliary, who has given so much of her time and effort in assisting us with the successful running of the Auxiliary. I appreciate the advice and help of our Advisory Committee, and most of all my husband's understanding, good judgment and sound advice.

It has been a privilege to serve the Auxiliary as its President, an experience I shall always cherish.

Thank you sincerely.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended acceptance of the remarks with the following comments:

"We are again indebted to our wives for a busy year of activity as reported by their President, Mrs. Henry Scovill.

"Their theme this year, 'Friendship Through Service,' well describes the spirit of their work.

"The programs developed by them for their own information in medical and educational fields must have done much to keep them in touch with current problems. An example is a program on 'Hallucinogenics, and Our Young People.'

"During the past year their contribution to AMA-ERF increased 27 per cent, and Macomb County won a national county achievement award for the largest per capita contribution in its category.

"Our wives continue to sponsor Health Career projects both financially and by active participation. They increased their activities in collecting drugs and supplies for World Medical Relief. They have worked in many mental health programs.

"Our Auxiliary continues to promote good legislation, both State and national. All these are things we would like to do if we had time. Thank God for our wives!

"Unfortunately, only a few more than half the eligible doctors' wives belong to the Auxiliary. If yours does not belong, urge her to join. They need her!"

THE HOUSE adopted the report of the Reference Committee.

9. Report of the Michigan State Medical Assistants Society — Mrs. Alta Greene, President

The Tenth Annual Convention of the American Association of Medical Assistants was held in St. Louis, Missouri, in October, 1966. Michigan was represented by four delegates and two alternates. Several of our Michigan members attended, as well as Miss Helen Schick, Educational Coordinator for Michigan Blue Shield and Honorary Member of the MSMAS, and Mrs. Marge Karker, our part-time secretary and liaison representative of MSMS.

Dr. Glenn Millard, Chairman of the MSMAS Advisory Board, attended the AAMA convention along with Mrs. Millard. We were honored to have Dr. Millard chosen as Chairman of the Advisory Board of the American Association of Medical Assistants.

MSMAS is well represented in the national organization this year. Mrs. Betty Lou Willey was elected Speaker of the House of AAMA, and two committee appointments were made from Michigan, namely, Awards Chairman, Mrs. Nelda Gasperson, and Legislation Chairman, Mrs. Dorothy Brandis. Betty Lou Willey is again a candidate for AAMA Speaker of the House for 1967-1968.

The county officers' and committee chairman conference was held in Battle Creek in November with an attendance of 131 members and guests. Mrs. Diane Place, of the U. S. Food and Drug Administration, spoke on "Quackery in the Health Field."

The President and Vice President represented the MSMAS at the Michigan Health Council meeting in January 1967 at the Kellogg Center at MSU in East Lansing.

The Tenth Annual Educational Seminar was held at the Hayes Motor Hotel in Jackson on April 23, 1967 with an attendance of 158. Three very interesting speakers made up the program.

Approximately 45 members and guests attended the fourth consecutive Upper Peninsula Seminar hosted by the members of the Marquette-Alger Society in Marquette in July 1967.

The 18th annual convention will be held this week at the Morton House in Grand Rapids. There will be approximately 80 delegates representing 21 counties at the fourth House of Delegates. Mrs. Elvera Fischer, President of the American Association of Medical Assistants, will be the speaker at the President's luncheon on Wednesday. One of the features of her presentation will be an explanation of the educational program offered by AAMA. Several other interesting speakers will highlight the program.

Total membership as of June 30, 1967 was 739. At present there is some progress being made in attempting to organize three new county societies, namely, Mecosta, Isabella and Gratiot.

We were especially pleased to have the President of MSMS write a guest editorial which appeared in our August Bulletin. We hope to give others the opportunity to present such an editorial for future publications.

The in-service educational program continues in some counties. To bring a closer alliance between the AAMA and the county and State chapters, the AAMA has provided each State with a trained area counselor who is available to help with the states' over-all educational program. MSMAS hopes to eventually set up a leadership training program on a state level to present educational material to component societies in Michigan. Many junior colleges are offering the opportunity for continued education of medical assistants.

The AAMA is in the process of setting up a standardized training course for approved junior colleges throughout the United States — probably a two-year course leading to an Associate Arts degree in medical assisting.

Highland Park Junior College was used this year for the testing center for the certification examination in June. Two more from Michigan passed this examination, making a total of eight Certified Medical Assistants in Michigan.

A recently appointed MSMAS Projection Committee has met, and much discussion has been held regarding numerous ways of improving our society. Recommendations will be made to the MSMAS House of Delegates on September 27.

We have actively participated in the fight to preserve the practice of medicine. Many letters and telegrams have been sent and phone calls made by our members to State representatives, opposing S.B. 227 — the chiropractic bill.

We appreciate the fact that *Michigan Medicine* has published many articles pertaining to our activities.

Closer liaison between the MSMS and MSMAS has been accomplished with the help of Mrs. Marge Karker. We sincerely hope it will be possible to continue to have this valuable relationship with the MSMS this coming year.

We also appreciate the work of Miss Helen Schick, Educational Coordinator of Blue Shield, for she has given countless seminars in a number of Michigan cities to bring information on Medicare and Medicaid to employees in doctors' offices.

We wish to thank the MSMS for granting us the privilege of using their facilities in East Lansing for our Board of Directors meetings. We especially wish to thank our Advisory Board, Dr. Glenn Millard, Dr. F. C. Cretsinger, Dr. W. T. Davison and Dr. T. J. Trapasso, for their advice, cooperation and guidance.

The members of the MSMAS appreciate the continued interest and assistance given by the MSMS, and you can be assured that you will continue to have the full cooperation of our society in the future.

We sincerely welcome any members of the MSMS to attend any or all of our meetings at the Morton House on Wednesday and Thursday of this week.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended acceptance of the remarks with the following comments:

"We are pleased to note the reports of national and State meetings attended by our Assistants. The Tenth Annual Educational Seminar program appears to have been especially worthwhile.

"We appreciate the invitation to the Eighth Annual State Convention held in Grand Rapids this week. The program presents an interesting format. We regret some counties' medical assistants societies have ceased to function. The membership of this Society should be larger. It could be if we urged our aides to join.

"With the advent of many courses in community colleges we should urge and help our aides to enroll. The dividends would be to the community and to ourselves."

THE HOUSE adopted the report of the Reference Committee.

10. Progress Report on the MSMS Judicial Commission — Donald N. Sweeny, Jr., MD, Chairman

The members of the Judicial Commission wish to thank you, Mr. Speaker, for setting aside time from your busy agenda to allow me as their Chairman to review the highlights of the activities of that Commission during the past year.

This House of Delegates in its infinite wisdom saw to it that the Judicial Commission should be autonomous as a third arm of the Michigan State Medical Society, unhampered by political or administrative action. Although jealous and mindful of this unfettered, albeit powerful, position, your Judicial Commission has organized its activities slowly so that policy statements and interpretations promulgated by it might be fair, practical, and respectful of the rights and dignities of physicians, other members of the health team, as well as those of the patients whom we serve.

The Constitution and Bylaws of the Michigan State Medical Society charge the Judicial Commission with six duties: Appellate powers at the State level in all matters relating to ethical professional conduct. Mediation and discipline of members of component medical societies is perhaps the most significant of our responsibilities.

I am pleased to report to you today that all complaints except one matter, involving a question of ethical conduct by a member of our Society, have been resolved at the local county level. This is a fine testimonial to the ability and dedication of those physicians serving on mediation, grievance and ethics committees of our local county groups.

An additional duty of the Judicial Commission is to make binding ethical interpretations and decisions in accordance with the standards of the American Medical Association.

Responding to the request of a component county medical society and after studying the problem in depth, the Judicial Commission has published two policy statements for the Michigan State Medical Society. These should be of keen interest to all physicians of Michigan.

The first concerns itself with "the association of doctors of medicine with doctors of osteopathy in osteopathic institutions and hospitals." This was uncharted territory and no opinion at any local, State or national level had been promulgated concerning this association.

Briefly, our opinion holds that the ultimate consideration must rest with the question:

"Are the standards of practice of the osteopathic hospital or institution under consideration equivalent to the best available in the local, community medical facility? If this is not true or even if the doctor of medicine disregards the standards of the osteopathic hospital under consideration and thereby attempts to maintain his own high medical standards and judgment within the realm of administrative propriety, this physician risks the charge that he is not safeguarding the dignity of medicine by avoiding the self-imposed discipline of the available medical institution to the detriment of his patient. Such activity is not ethical."

This policy statement has been forwarded to all components of the Michigan State Medical Society and to the American Medical Association, and it has pleased your Judicial Commission to have been complimented by the Judicial Council of the American Medical Association for the practical approach we have taken. We hope that the policy enunciated will aid in our continual closer rapprochement with osteopathic physicians. We encourage comments from your local groups in this regard.

The second policy statement from your Judicial Commission concerns "The use of prescription blanks bearing the name of a pharmacy or drugstore printed thereon." We have reaffirmed the opinion of the American Medical Association Judicial Council, which states empirically that to use such prescription forms restricts the patient's free choice and is therefore not ethical. To insure that there be no misunderstanding on this matter by either physicians or pharmacists, we have informed at once both the Michigan State Medical Society membership and have asked that the Michigan State Pharmaceutical Association so inform its members.

I will not detail all other items that are presently on our agenda, but I would like to tell you about two further problems which we are researching.

At present the Judicial Commission has been studying the ethical (or otherwise) relationship of physicians' participating in bank card credit programs. This involves an exploration of legal, philosophical and ethical principles.

Another item concerning us is the regulation of the physician who is physically or mentally incompetent. This is a concern of an ad hoc committee within the Judicial Commission and this small group is working in liaison with the MSMS Legal Counsel and the Michigan Board of Registration in Medicine in an attempt to formulate an appropriate mechanism which will solve these problems within the respect and dignity of both physicians and the patients for whom we are responsible.

We anticipate that the Judicial Commission will become more involved with matters requiring ethical interpretation as knowledge of the availability of our Commission as a source for these interpretations becomes more widespread.

I am confident that your Commission can meet these challenges.

The Speaker stated that this was a progress report of the Judicial Commission for information to the delegates and would not be referred to a reference committee.

11. Report of Michigan Delegation to the AMA — Luther R. Leader, MD, Chairman

May I first say that there is a report in the forepart of your Handbook on the AMA delegation's doings in Chicago. However, there are a few other remarks I would like to make.

In the first place I want to say that the AMA delegation works — and it works hard. We have many problems brought to us. Some are brought to us at the last moment, as things are brought here; but we do try to work together, and we do have a good working unity of your AMA delegates. You can all be assured of that.

Nearly all the delegates and many of the alternates are veterans, experienced and knowledgeable. These fellows know the ropes. We all know the ins and outs, and whether we should or whether we shouldn't. However, we are always open to new ideas, and we must of course dicker with other people on certain things.

Your delegates to the AMA attend the meetings, and you can be assured that their influence is felt on the floor of the House of Delegates. There is no hesitancy on the part of our men to speak on the floor. Some are more fluent than others, but we do get up and express our opinions, and the House of Delegates knows that Michigan is really represented.

I think it is also fair to say that our rapport with the AMA is good. We have made recommendations that the MSMS members serve on AMA committees, and some of them have been accepted. However, we are not satisfied. We are still working to get more of our people on more committees. We are proud to report that we received another appointment just the other day.

Dr. Hudson, last year's AMA President, spent many hours addressing Michigan audiences during 1967. Both he and Dr. Blasingame attended the meeting of The Council at Mackinac Island last summer, and we were able to talk to them personally. They gave us a great deal of their time, and I think they learned a lot from what we had to offer them, as well as things we learned from them.

Dr. George Slagle, one of our members, is doing a fine job as Chairman of the AMA Council on Medical Services. It is a most difficult job to handle especially in these days, and you can be assured that George is in there pitching and always knows when to do things and when not to do things.

Jack Brown, field representative of the AMA, is here, and he follows through on requests made upon him; he does a great job and works with us excellently.

I could go into other things, but I think it is unnecessary, except to add that the objectives of your delegates will not be gained until Michigan has a member on the AMA Board of Trustees and more members on AMA Committees. We keep talking about this all the time, and I know we will succeed in due time. We believe both of these things are possible of accomplishment, and probably in the very near future.

We lost a great asset in the passing of Dr. John Sheldon of Ann Arbor as an AMA delegate from a specialty group meeting regularly with our delegates. We miss John very much.

The fact that many AMA section delegates are from Michigan is indicative of the high caliber of Michigan doctors and the esteem with which members of the medical profession of this State are held by their peers in other states. We appreciate the fine cooperation we receive from section delegates.

If there is anything that anyone in the audience or any of our group feels we should do that we are not doing, we will be glad to receive any recommendations, because we want you to know that we are out to get farther up in the AMA.

(The following report of the Michigan Delegation to the AMA was presented to the Delegates in printed form.)

The Speaker, Walter C. Bornemeier, MD, called the House to order at 10 a.m. Sunday, June 18, and ended at 1:12 p.m. Thursday, June 22, setting the AMA House of Delegates two new records.

One was attendance: 95% of authorized delegates attended the opening session and 100% – 242 out of 242 – were present both Tuesday and Wednesday; and Thursday the final attendance still stood at 240.

The other was the accomplishment, with the House being presented with 151 items, on which action was taken, including a record to that of 123 resolutions and 18 reports.

Dwight L. Wilbur, MD, San Francisco, California, was elected President-Elect, and will be installed as the Association's 123rd President at its annual convention in San Francisco, June, 1968.

Walter C. Bornemeier, MD, Chicago, was re-elected speaker of the House and Russell B. Roth, MD, Erie, Pennsylvania, re-elected Vice Speaker.

The four present Trustees vacancies were filled by each succeeding themselves, and Dr. Edward R. Annis was elected to complete the term recently vacated by the death of Homer L. Pearson, MD, Miami, Florida. Burt L. Davis, MD, Palo Alto, California, was elected to complete the term as Trustee vacated by the resignation of President-Elect Wilbur from the board.

George W. Slagle, MD, Battle Creek, was elected to succeed himself on the Council of Medical Service and Elmer G. Shelly, MD, Pennsylvania, was elected to succeed himself on the Judicial Council.

The AMA Distinguished Service Award was presented by the House of Delegates to E. W. Ochsner, MD, of New Orleans, Louisiana.

House Actions

The Disability Insurance Program Committee's report as adopted recommended that the House authorize the Board to make every effort to continue the AMA Group Disability Insurance Program with the same premium benefit structure, with accompanying guidelines to aid the Board in negotiating and executing the necessary contracts in the future operation program.

The issue of therapeutic abortion generated intense interest among certain groups, especially among state legislatures.

The House agreed in keeping the modern scientific knowledge; containing necessary safeguards and permitting the physician to exercise his personal conscience and medical judgment in the best interests of his patient; overriding objectives in any medical decision. Five objective policies were presented, and "It is to be considered consistent with the principles of ethics of the AMA for physicians to provide medical information to state legislatures in their considerations of revision and/or the development of new legislation regarding 'Therapeutic Abortion'."

Regarding the Title XIX Program the House made it a policy that "The medical professitn should not take a firm stand in support of the Title XIX approach in improving the health and the delivery of health care services to the needy of the nation."

Recommendations adopted by the House were: that the medical profession take a strong stand in support of implementation of Title XIX while still seeking such changes in federal legislation and/or regulations as will improve this program; that it urge organized medicine to take a leading role in formulating and directing Title XIX programs at the state and local level . . . and that it incorporate in such planning the use of existing voluntary mechanisms and private insurance carriers, whenever feasible, utilizing the usual and customary fee principle, thus bringing within the mainstream of present medical care systems the provision of quality health care for all Americans.

Medicine and Osteopathy

The House adopted a resolution authorizing the Board of Trustees to begin promptly negotiations directed toward beginning change of schools of osteopathy to schools of medicine, and to also authorize the Council on Medical Education to undertake negotiations to establish means by which selected students, with proven satisfactory scholastic ability in schools of osteopathy, may be considered by schools of medicine for transfer into medical school classes.

The primary issue in the relationship of medicine and osteopathy, as recognized by the House, seems to be not that of cultism as opposed to science.

Hart Bill

The House reaffirmed the Association's opposition to the Hart Bill (S 260) and its support of direct billing under Part B of Medicare on the basis of a physician's itemized statement charges.

Generic Prescribing

A resolution was adopted by the House, asserting that the AMA again reaffirm its policy that physicians should be free to use either the generic or brand name in prescribing drugs for their patients; and to encourage physicians to supplement medical judgments with cost consideration in making their choice.

Noted the Following Items

That a double standard of policy often exists between so-called "hospital based specialists" and other types of practitioners, with respect to hospital staff appointments and endorsing the principle of a single standard with respect to staff appointments, hospital departments and service as a means of assuring maximum freedom of choice of physicians by patients and of consulting by staff members.

Requested the J. C. A. H. to encourage the acceptance, whenever possible, of physicians elected or appointed by the medical staff to the board of trustees with full voting rights as the most effective form of liaison between the medical and hospital governing authorities, opposing the establishment of a racial quota for hospitals.

Reaffirming the Association's policy regarding tobacco and health and promising vigorous continuation of its measures for corrective action.

Reaffirming the Association's opposition to requirements foi certification and re-certification.

Supporting confined research and control measures for venereal diseases.

Urging that disposable hypodermic syringes be discarded in such a way to prevent their possible re-use.

And finally, welcomed as its guests winners of the AMA top awards at the 18th International Science Fair held in San Francisco: Susan T. Beatland (Electrophoretic analysis of blood serum), and Stephen R. Igo (Exhibit of a synchronous intrathoracic auxiliary ventricle).

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended acceptance of the report and congratulated Dr. George Slagle on his being elected to succeed himself on the AMA Council on Medical Service.

THE HOUSE adopted the report of the Reference Committee.

12. Report of Michigan Medical Service — John M. Wellman, MD, Chairman of the Board

Michigan Blue Shield's 1966 record of action and productivity was laid before The Council in our formal annual report.

This report is an extension of that document, highlighting the events of the first six months of 1967 and pinpointing several of the most important developments in the corporation's history.

In that regard, our reference is to the Board of Director's authorization of a general medical care utilization review and approval of programs relating to new payment techniques for physicians, expansion of basic benefits, adoption of home and office and prescription drug programs.

The utilization review, expected to require at least a year's effort and costing $100,000, has the broad objective of re-evaluating, refining and developing techniques to measure the utilization of medical care.

It will involve use of computers, professional researchers, consultants and liaison with professional societies.

The payment mechanisms and new benefit programs are Blue Shield's answer to demands from the public, private and medical sectors that the voluntary prepayment system take leadership in developing health care programs consistent with the times.

How Programs Were Developed

The programs were developed starting early in 1966 by Michigan Blue Shield management, working with a special Ad Hoc subcommittee of the Board of Directors, after a detailed analysis of Blue Shield's current health care programs and their ability to function in the current environment.

The project was undertaken against a backdrop of impending major collective bargaining in the automobile industry, subscriber unrest, growing physician discontent, great activity inside and outside of medicine involving economic, social and political change, and Blue Shield's tremendous job of implementing Medicare and Medicaid.

Many forces were at play, some controllable and some not. Michigan Blue Shield had an urgent request — if not a mandate — from the public and medical communities to search out problem areas and take the leadership in developing programs consistent with the times and better in every sense than those conceived by government planners.

We believe we have met the challenge.

Variable Fees

With respect to the medical profession a system of variable physician fees has been developed which eliminates patient income as a fee-determining factor.

The Variable Fee program will pay the reasonable charge of the physician for a covered service, based on concepts of "customary," "prevailing" and "reasonable," as defined by the House of Delegates at their 1966 session.

In determining the reasonable charge, Blue Shield will consider the customary fees charged by each physician and the prevailing range of fees charged by others, geographical location, and whatever unusual circumstances or medical complications may have been involved requiring additional time, skill, and experience in connection with a particular service or medical procedure.

Physicians may periodically change their charge patterns while Blue Shield also will periodically review and adjust determination of the prevailing range of fees. What is most important, however, is that no fixed-fee schedule of payments made universally to all physicians will apply.

By design, the Variable Fee program is intended to be flexible and constantly reflect those adjustments in physician charge levels which may be expected to occur periodically.

Where differences exist between Blue Shield and a physician concerning charges involving unusual circumstances, they can be brought to an appropriate local Medical Society Review Committee and Blue Shield will accept the Committee decision and pay the recommended fee.

Extended and New Benefits

With respect to improvements in consumer benefits, all generally accepted surgical procedures will be covered. There are no limits on the number of days coverage for general medical care. The waiting period in most maternity services is eliminated. Emergency first aid is liberalized. The number of patient consultations is provided on the basis of medical necessity.

In the Home and Office program, benefits will be available for regular visits in the physician's office, in the patient's home, and in the hospital outpatient department.

The Prescription Drug program involves legend drugs only obtained from a pharmacy, a physician's or dentist's own supply, or the pharmacy of a hospital. Drugs will be available on a full or deductible payment basis.

Programs in Public, Professional Interest

Based on the findings of management and the Ad Hoc Committee, Blue Shield believes these programs are not only in the public and professional interest but the lack of them left a health care vacuum into which, in time, government was sure to rush.

Development of the programs had a high priority in the first six months of 1967 and that priority, with respect to implementation, will continue in the second half of the year.

Six-Month Corporate Activity Review

There were other interesting corporate activities during the first six months of 1967 as may be noted in the following items:

- Enrollment continued to reach new highs. There were 4,203,000 members enrolled in regular Blue Shield programs at the end of June, 1967 — five per cent higher than the same time in 1966. When coupled with government programs and the over 65 complementary coverage program, the number of persons covered by Blue Shield in one form or another exceeded 5,200,000, or more than half of the population in Michigan.
- Growth and stability were reflected further in financial statements showing assets of 78.8 millions and liabilities of 35.8 millions at the end of June, 1967. At the same time last year, assets were 70.6 millions with liabilities of 36.9 millions.
- Employee rolls reached 1,099 (nearly double that of a year ago) based on the workload generated by the M-75, Medicare and Medicaid programs.
- A program of increased payments for Special Medical Care and consultations was developed by the Medical Advisory Committee and adopted by the Board February 1, 1967. The program for special medical care more than doubled payment for such care over regular medical care.
- John C. McCabe, Blue Shield President, testified before the Congressional House Ways and Means Committee considering amendments to improve administration of the Medicare Law.
- Rate reductions of 23.5 per cent for 185,000 Blue Shield subscribers carrying complementary coverage and expanded benefits for 152,000 other "over 65" subscribers

were announced June 22, 1967, with an effective date of October 1, 1967.

- The Board of Directors approved construction of a new home office building in downtown Detroit in co-ownership with Blue Cross. The building will be located on certain urban renewal land and an offer to buy such land has been officially filed with the City of Detroit.

Operations

Blue Shield's growth in its regular programs, plus the activity generated by governmental programs, was reflected in the number of claims submitted for payment during the first six months of 1967 and the actual payout to providers of service.

Projecting first half year receipts over a 12-month period, Blue Shield was processing M-75, Medicare and Medicaid claims at the rate of nearly six million a year and paying providers at the rate of approximately $175,000,000 a year.

Acquisition of additional Blue Shield manpower and space to house them which were problems in the first six months of 1967 will become more acute in the last half of the year as Blue Shield's business expands and new programs are implemented.

Administratively, M-75 – the heart of Blue Shield business – posed few problems during the first half of the year, and efforts to break through administrative barriers and to conduct our stewardship of Medicare and Medicaid in a businesslike, efficient manner are continuing, and with success.

Briefly, this is Blue Shield's experience in three major areas of operation:

Regular Business

Receipts during the first six months of 1967 increased over the same period in 1966 by 13.9 per cent, or 224,400 claims.

Total claims for the six month period were 1,810,200 or 16.7 over forecast and at an annual rate of approximately 3,600,000.

The claims represented nearly 4,000,000 procedures, of which 2,380,000 were approved for payment and 1,423,000 returned for review and reprocessing.

Subscription income for the first six months of 1967 was $71.1 millions while payments for benefits during the period amounted to $58 millions.

Medicare

Gross receipts for the first fiscal year ending June 30, 1967, were 1,115,791 bills – only 61,209 less than forecast.

In the first six months our payout to physicians was $2,982,380. In the second half (the first six months of 1967), we paid $15,621,377.

We received 214,419 workable or properly completed receipts and processed 124,719 during the first half of the fiscal year. In the second half, receipts were 696,230 of which 686,594 were processed.

Claims received from physicians and facilities on an assigned basis climbed from 58.3 per cent in the first half of the year to 70 per cent ending June 30, 1967, or 20 per cent above the national average.

Medicaid

Having started in October, 1966, statistics on the Medicaid program reflect nine month totals. Thus far, the program has generated 427,231 claims receipts, of which 311,224 were received in a three-month period ending June 30, 1967.

On the same basis, Blue Shield has processed 376,574 claims of which 309,276 were handled in the 90 days ending June 30, 1967.

Payouts during the nine-month period totaled $4,353,144 of which $3,838,370 were paid in April, May, and June, 1967.

Administrative Refinements

While we believe we have weathered the worst with respect to administration of the government programs, we anticipate further improvements as state and federal agencies refine their regulations and administrative techniques.

On the state level, Blue Shield continues to encounter delays in processing claims because there is no up-to-date list of Medicaid eligibles.

On the national level, the sheer volume of Medicare and the problem of receipted bills among other things have tended to slow up the payment process to physicians. Here again, time, more claims experience, and changes in federal administrative rules are expected to minimize the problem, hopefully before the end of the year.

Medical Economic Climate

As we enter the second half of 1967, there is uneasiness and uncertainty in the medical economic climate.

Major collective bargaining sessions are under way in the auto industry and their resolution of health care issues could have a major impact on the pattern of prepaid health care for years to come.

As discussed earlier, Blue Shield has been made aware of (1) subscriber unrest, (2) the growing physician discontent with current fee levels as manifested by increasing departicipation, and (3) the general environment of economic, social and political change which produced Medicare and Medicaid.

However, Blue Shield is on the offensive. It is prepared. We are confident that Blue Shield has the means, the know-how and the programs to meet the needs of the public and to insure leadership of the private sector.

House Resolutions; Blue Shield Actions

We wish to report on our consideration of certain resolutions adopted by the House of Delegates in 1966 in relation to Michigan Blue Shield. By number and in summary they are:

Number 16, concerning the definition of "customary, prevailing and reasonable fees:" This was referred to the Medical Advisory Committee and subsequently implemented in the variable fee plan. The plan uses the specific definitions of the House of Delegates.

Number 26, concerning the payment of all members of physician teams: This was endorsed by the Medical Advisory Committee.

Number 29, concerning the variability of "usual and customary" fees: Again, the new programs take care of this.

Number 35, concerning implementation of Michigan Relative Value Study for nomenclature and coding: Blue Shield is using MRVS nomenclature where applicable. In the case of office calls and inpatient medical service, doctors are only reporting one or two basic types of care for their services. In other instances, the numerical coding structure as outlined by MRVS is not consistent with our computer programs and, therefore, we have used the M-75 code number, which in no way limits the payment. We are continuing re-examination of administrative techniques.

Number 36, the essence of which is that the fee schedule is outmoded: The variable fee program eliminates schedule.

Number 41, concerning avoidance of dual benefits: The new programs do this, as does the steel contract. As it is, a coordination of benefits rider to this end has been in effect.

Number 56, a two-part resolution concerning the need for utilization review and urging Michigan Blue Shield to take a "forward look" in the development of health care programs: A utilization review program and research project has been authorized by the Board. New programs have been approved by the Board covering new payment mechanisms for physicians, extended benefits, home and office calls and prescription drugs.

Number 66, concerning treatment of alcoholism as a disease entity: Michigan Blue Shield routinely pays for such care in an accredited institution in which other benefits are provided.

Number 68, concerning reports of administrative expenses of Titles XVIII and XIX: Such report is specifically forbidden by the federal government, except through it.

Michigan Blue Shield is pleased to give you this summary. We continue to drive for administrative efficiency, for equity for doctor and patient, for protection of medicine's individual relationships and judgments, for realization of our common goals.

(The following report was presented in printed form to The Council on July 14, 1967, and to the MSMS House of Delegates, September 25, 1967.)

Michigan Blue Shield New Fee and Benefit Program

This is Michigan Blue Shield's report on major revisions in its health care programs as presented to The Council of the Michigan State Medical Society, July 14, 1967, at Mackinac Island, Michigan, and to the House of Delegates of the Michigan State Medical Society, September 25, 1967, at Grand Rapids, Michigan.

The presentation was made by the following Blue Shield officials: Dr. John M. Wellman, Chairman of the Board; Mr. John C. McCabe, President; and Dr. James B. Blodgett of Detroit, Vice-chairman of the Board, who, as chairman of a special subcommittee, has been deeply involved in an in-depth analysis of Blue Shield programs — past, present and future.

What is discussed here is, in substance, a recapitulation of Blue Shield's oral and visual presentation to The Council, plus additional commentary growing out of the dialogue which developed relating to physician participation, payment mechanism and other salient points of the new programs.

The process of developing revised Blue Shield programs took more than a year.

This presentation will be a capsulized version of that process and is divided into four major sections:

1. A review of the background and environmental situation leading to the program analysis.
2. A commentary on the techniques of the analysis.
3. A discussion of the decisions and results.
4. A summary and discussion of the future.

I. The Background of Review

Essentially, Blue Shield's decision to revise its programs was based on the belief that a delicate balance between the public and private sector in medical economics is best served by a vibrant, vigorous and creatively oriented Blue Shield Plan.

But there were other compelling reasons for change, including sociological and political pressures which had been building since the beginning of the 1960's and which were climaxed in 1966-67 with such innovations as Medicare and Medicaid.

They were revolutionary mileposts in the history of American medical economics that brought with them concepts including a broadened scope of benefits which could not be ignored in the evolution of modern health care.

That Michigan Blue Shield be the catalyst for change in a changing medical care environment was not inconsistent with its 27-year history of leadership in the voluntary prepayment system and its role in 1966.

Michigan Blue Shield in that year had the highest benefit payout of any Blue Shield Plan in the country, $120,819,340.

Michigan Blue Shield had the highest average payment per service of any of the largest Plans in the nation.

Michigan Blue Shield had a high degree of physician support historically and a record showing that more than 90% of its subscribers received full service benefits.

In terms of community penetration, Blue Shield had more than 4½ million subscribers on its rolls which, when coupled with Medicare and Medicaid, brought the total of persons served by Blue Shield to approximately 5,200,000, or close to 60% of the state's population.

Nationally, Michigan Blue Shield had demonstrated by performance that it was an on-going, vital, growing organization.

Michigan Blue Shield was also cognizant of the imminence of major collective bargaining in the automobile industry starting in July, 1967, and the fact that the automobile industry represented 40% of Blue Shield's business. Blue Shield remembered that in 1964 it was not adequately prepared for the health care program adopted by labor and management.

Blue Shield was also aware of customer and consumer attitude relating to service benefits and their scope, and growing physician discontent, some valid and some invalid.

The bulk of the physician dissatisfaction related to fee levels, lack of recognition of medical specialties and families with dual income and dual insurance. There was also dissension growing out of the sociological and political times. Physicians were unhappy about Medicare and Medicaid and they used departicipation as a technique of dissent.

The public consumer area was also unsettled.

Complaints were increasing about so-called "overcharges" by physicians.

Subscribers were unable to get full service benefits.

In many cases subscribers' incomes and the rising economy had made them ineligible for service benefits, yet not able to cope with higher physician charges.

It was apparent that the program created 10 years ago was no longer doing the job.

More proof lay in an analysis of accelerated changes in medicine — both logistically and scientifically. Medicine had become specialized and there were many pressures on the techniques of delivering medicine to the patient; i.e., group practice, hospital design, administration and facility use. Underlying the problem was the increased cost of medical care in hospitals as well as charges made by physicians, plus demands of the public for more services.

There was dissatisfaction among larger employers and those who work for national employers. Both want benefits which are substantially the same and not duly affected by geographical averages, and they are apparently determined to get them.

The problem of dealing with large national entities is growing. It is obvious in the automotive industry, where, since 1962, the large automotive employers have cancelled the benefits of 20 Blue Shield Plans outside of Michigan in favor of commercial insurance companies. The federal employee program is another example. A steel industry program effective this summer is another. Michigan Blue Shield's deliberations, therefore, have had to consider the implications nationally.

There were other indications for change.

In 1966, the House of Delegates adopted Resolution #56 commending Blue Shield for its accomplishments in the past and urging the Michigan organization to:

> ". . . . continue its efforts to administer more efficiently to aid in developing meaningful techniques of utilization review in cooperation with the profession, to look for effective ways to correct inequities and inadequacies in programs in a manner satisfactory to the consumer, to extend benefit levels and, by so doing, demon-

strate again that the mechanism of Blue Shield, coupled with appropriate professional participation, gives the consumer good health care coverage."

The House of Delegates also adopted Resolution #29 in which it was stated that the physician's and surgeon's usual and customary fees be recognized as flexible in nature and variable from time to time.

A major factor affecting both the nature and timing of any analysis of Blue Shield programs had to be the substantial growth in Blue Shield's operating structure which began in 1966.

Many things contributed to this growth. Included, of course, was the implementation of Medicare and Medicaid. Also, there was the fact that additional benefits in the automotive industry were effective in that year. Finally, there was a Blue Shield decision to perform and to do many administrative tasks in connection with claim administration which had been performed previously by Blue Cross.

In addition to the administrative impact, the initiation in 1966 of both the Medicare and Medicaid programs had both psychological and philosophical effects. They generated negativism among physicians and subscribers alike, with much of it directed at Blue Shield's M-75 programs.

Medicare payment techniques were different. So were the scope of benefits. Many concepts and traditions were no longer applicable. The fixed fee schedule was inappropriate. There was no relation to income. There was a broad scope of coverage including home and office medical care. In terms of Title XIX, the disparities in coverage were even more so when compared to M-75. Yet these government programs cover more than 15% of the population in Michigan.

Taken collectively, then, 1966 was a year of great change and great activity in medicine involving many economic, social, and political changes, occurring inside of medicine as well as outside. Many forces were at play, some controllable and some not. It was evident that private prepayment plans were on trial and faced disaster unless they could demonstrate they were not dying on the vine.

This was the temper of the times. This was the environment in July, 1966, in which Blue Shield management, working with an Ad Hoc Committee of the Board of Directors which it had asked to be established, began its development of programs designed to prove that the private voluntary prepayment system can do a better job in every sense than government.

II. The Format of Study

Initially, the committee comprised five physicians and three laymen of the Blue Shield board. To insure the broadest base of attitudes the committee was expanded in August, 1966, to nine physician members of the board representing various aspects of the medical profession and five lay members of the board representing management, labor, farming, and industry.

The committee established these objectives: Identify services Blue Shield should consider offering to subscribers; determine amounts to be paid for these services and payment mechanism to be utilized, and establish necessity of instituting quantitative utilization control mechanism.

Because it was felt these viewpoints should be supplemented by opinions outside the immediate Blue Shield environment, representatives of the medical profession, management and labor were invited to express their views on the future of Blue Shield.

Meetings were held in Detroit, Gaylord, Grand Rapids and Iron Mountain with M.D.'s, D.O.'s, presidents of county medical societies, representatives of management, labor, farming and the academic community.

Questions were raised regarding benefit scope, physician payment mechanisms, utilization control, government involvement in health care needs, use of the income level in benefit structure and Blue Shield's role in the community. All persons — professional and lay — were given an opportunity to express themselves.

The most significant and universal indication of dissatisfaction from physicians related to payment levels. Physicians were generally critical of M-75 fee levels and the fact that they were inconsistent with the current economic situation.

The medical community recognized the need for Blue Shield to be more aggressive in providing health benefits to thereby forestall further intervention by government in the private health care sector.

Concerning benefits, the medical profession agreed that collective bargaining and pressures of government programs had created demands upon Blue Shield to expand benefits.

Specific areas suggested for such coverage included home and office visits, developments of a comprehensive medical care package and a prescription drug program based on certain controls.

Regardless of the payment mechanisms, physicians appreciated there should be controls providing predictability of cost to Blue Shield and the subscriber. The physicians recognized that this was important to the insurance concept and to the subscriber.

In terms of utilization review and control, physicians generally agreed there must be an adequate mechanism to evaluate both the quantity and quality of care and that the medical profession should assume responsibility for such a program in conjunction with Blue Shield.

Industry, labor and others asserted that Blue Shield has a mandate to assume the leadership role in the health care field and that its relationship with the medical profession provides the unique experience and commitment to the health service concept so necessary for leadership.

The spokesman said there was crucial need for a degree of meaningful formal physician participation. It was described as a problem which Blue Shield must solve since participation represents the backbone of the organization and that consideration would have to be given to the type of program and reimbursement method involved to induce the vast majority of physicians to participate.

The representatives from industry, labor and the public urged that:

1) Blue Shield should look to the entire spectrum of medical care and make it available and flexible enough to meet the changing needs of the community.

2) Blue Shield should expand research and development activity so as to exert its leadership rather than respond to a customer designed benefit demand.

3) Blue Shield should take a leading role concerning national account needs or risk damage to the Blues nationally and locally.

In terms of benefit scope, the management representatives declared that Blue Shield benefit packages should be inclusive, not created by a multiplicity of riders.

Labor representatives said there was need for a comprehensive package with greater emphasis on preventive care, first dollar coverage in prescription drugs, dental care, and home and office and visual care. Some labor officials expressed concern over dissimilarity of benefits received by their members in other sections of the country.

The academic community said there should be greater emphasis on preventive care and suggested a wide spectrum of medical services including home and office calls, drug costs, and dental care.

The opinions of lay people were threaded with suggestions for uniformity of benefits and service benefits with assurance to subscribers of no additional costs. This point has been emphasized continually.

They were also fearful that any move away from the come-structure fee schedule would reduce the advantage the "Blues" over the commercial insurance companies.

Public members expressed fear and concern over untrolled increased fees under any program without fixed e schedules.

Without exception, all knowledgeable people recognized at Blue Shield has a responsibility for utilization and st control because of its close association with the medal profession.

The feeling was common that if Blue Shield and commercial insurance companies cannot or will not provide enefits where or when required, government intervention ill be inevitable.

It was also acknowledged by participants in the meetgs that larger management and larger labor are not reuired to go along with Blue Shield in any respect beause they are in no way committed to support Blue hield as an organization.

The committee also studied results of a survey conucted by the National Association of Blue Shield Plans ertaining to the attitude of other Blue Shield executives oncerning benefits and new reimbursement mechanisms.

In essence, it was their consensus that fixed fee schedles and income-related programs would disappear and hat home and office calls and prescription drugs would e added to the existing scope of benefits, all without reard to income level.

The Plan directors also agreed that Blue Shield's abilty to maintain membership and grow was dependent pon its ability to deliver what the public needs in health are coverage.

To compete with commercial insurance companies, Blue hield should provide consistent performance, utilization eview, predictability of cost, some orientation to local conomics and medical practice, specialized claim service nd participating agreements, the Plans concluded.

To supplement these sources of information, a survey was taken by an outside research firm involving 129 interviews with representatives of existing enrolled groups having 400 or more employees.

Responses indicated generally that government involvement in medical economics would increase and that additional benefits will be added to group contracts including home and office calls, prescription drugs and dental extractions.

The survey also suggested that lower income levels were no longer realistic and that a physician's fee should be based on services rendered, not the patient's income.

Again, the degree of meaningful formal participating physicians throughout the State of Michigan was a matter of concern.

A pattern of attitudes was emerging which clearly indicated that in developing new programs, Blue Shield should 1) take the leadership in developing programs rather than wait for the customer to suggest the programs; 2) move into uncovered benefit areas – based on priority of need, administrative feasibility and Blue Shield's ability to deliver the benefit; 3) encourage broad physician participation through commitment by the physician and just compensation for quality care to the subscriber; 4) remove income as a factor in determining benefit eligibility; 5) eliminate fixed fee schedules and incorporate variations in charge patterns in new payment mechanisms; 6) improve utilization review; and 7) develop new programs which lend themselves to national uniform delivery and meet the needs of national customers.

These seven factors were approved by the Blue Shield Board of Directors at their February 1, 1967, meeting. The Ad Hoc Committee at its March, 1967, meeting subsequently adopted two recommendations: 1.) Blue Shield should develop a program eliminating income as a factor in determining eligibility for benefits, and 2.) Blue Shield management should develop a program without fixed fee schedules.

The recommendations were based on management's analysis and assessment of the situation which indicated that: 1) a greater number of people are becoming ineligible for service benefits due to rising incomes, 2) MSMS resolutions have recommended the development of a no-income level, non-scheduled physician payment program; 3) fixed fee schedules tend to lag behind rising medical costs; 4) fixed fee schedules do not recognize variations in charges by geographic area and specialty; 5) the trend is toward physician payment programs without income levels and fixed fee schedules; 6) the impact of Medicare and Medicaid reduces need for income level and fixed fee schedule payment technique for low income groups; and 7) the difficulty of Blue Plans in providing uniform income level makes it necessary to seek national coverage.

Another reason was that, in general, physicians no longer set fees on ability to pay.

It was apparent that Blue Shield's existing programs were not consistent with the times.

It was also clear that physician payment was not currently appropriate, that there was public and physician dissatisfaction and that current programs did not have the capacity to deal effectively with changing health care problems.

III. Decision and Action

Accordingly, on April 5, 1967, the Ad Hoc Committee recommended and the Blue Shield Board of Directors subsequently approved at its May, 1967, meeting, revised programs designed to reflect more appropriate physician payment mechanisms which would eliminate the fixed schedule concept and eliminate continued use of patient income as a direct factor affecting physician charges and plan payments.

The Plan is called the Variable Fee Program.

There are five components around which it can best be described: 1) criteria for determining acceptability of charges; 2) method of determining reasonable charges; 3) participating agreements; 4) payments to physicians and subscribers; and 5) liaison with physicians.

Concerning the criteria for determining acceptability of charges:

Subject to certain maximums, which are actually the product of charge patterns themselves, the program will pay the reasonable charge of the physician for a covered service.

In determining a reasonable charge, Blue Shield will consider the customary fees charged by each physician and the prevailing range of fees charged by others. In addition, whatever unusual circumstances or medical complications may have been involved requiring additional time, skill, and experience in connection with a particular service or medical procedure will also be considered.

In combination, these provisions are designed to recognize differences in physicians' charges because of geographical locality, skill and training of the physician, and complexity of the service performed.

The terms "customary," "prevailing," and "reasonable" are used as defined in Resolution No. 16 as adopted by the 1966 MSMS House of Delegates, and which are as follows:

Customary: relates to the individual physician and the charge which he most commonly establishes as fair compensation for specific services.

Prevailing: relates to the range of usual charges made by physicians of similar ability and experience for the same service within the same specific socio-economic limited geographic area.

Reasonable: A fee is "reasonable" when it meets the "customary and prevailing" criteria or, in the opinion of a duly constituted medical society committee, is justified under what is considered a complexity of treatment which merits special consideration.

Concerning the method of determining reasonable charges:

The determination of reasonable charges is a process that revolves around two basic characteristics: 1) the payment of each physician's customary charges to his patients; 2) the payment of prevailing charges made for comparable services by his fellow physicians.

When fully implemented, a profile of services will be developed for each practicing physician. Also, a prevailing range of fees will be combined for each or all of the services performed and reported by individual doctors within a given area.

Under the program, physicians may periodically change their charge patterns. Also, Blue Shield will periodically review and adjust its determination of the prevailing range of fees. Further details appear later in this document.

It is most important that no fixed fee schedule of payments made universally to all physicians will apply.

A variation in payment is expected to reflect the variations in charges which will occur.

By design, the Variable Fee Program is intended to be flexible and fluid, and to constantly reflect those valid adjustments in physician charge levels which may be expected to occur periodically.

Concerning participating agreements:

Since the new program eliminates many of the historic controls on physicians' charges which were characteristic of fixed schedule, income ceiling plans, formal participating agreements are made more important.

From the physician's point of view, almost all economic obligations to participate have been eliminated. Because the new program will probably result in higher payments to physicians, a participating commitment to Blue Shield provides the consumer with some indication that these higher charges will be characterized by prudence and self-control. For this reason and others, in developing the program that was approved by the Board, no continuation of the per case participation technique was planned, since the arrangement appears to have no continuing purpose of validity.

Participating in Blue Shield is also important because it is looked upon by the public as a particularly important indication of physician cooperation and support for the organization and the programs in which physicians play a major policy-making role.

Consequently, the participating physicians under the new program will be obligated to accept their customary fees as full payment for covered services, regardless of the subscriber's income.

Concerning payments to physicians or subscribers:

1. Payment to participating physicians.

a. Payment will be made directly to participating physicians.

b. If the participating physician's charge exceeds his customary fee or the prevailing range of fees, Blue Shield's professional medical advisors will review the claim and pay it if unusual clinical circumstances or medical complications are involved.

c. If the level of the charge cannot be resolved between Blue Shield and the physician, he may bring the matter to the appropriate Medical Society Review Committee. The committee's decision will be accepted and benefits paid accordingly.

2. Payment to subscribers.

a. In cases where services are rendered by non-participating physicians, payment will be made directly to the subscriber.

b. Blue Shield will not pay that portion of a charge which exceeds the lower of (1) the physician's customary fee, and (2) the upper limit of the prevailing range of fees.

The only exception to this rule is where the upper limit of the prevailing range of fees is based on unusual clinical circumstances or medical complications.

c. In all other cases where the physician's charges exceed the upper limit of the prevailing fee range — except where it is clearly established that the patient has agreed to the physician's charges — Blue Shield will take every reasonable action to resolve on an individual case basis the matter without residual payment by the claimant.

3. Procedure to change charges.

Again there is fluidity in the program, recognizing adjustments are necessary in medical economics, the program provides that a physician may change his recorded customary charges not more often than once every twelve months by filing with Michigan Blue Shield a written 90-day notice of his intention and stating his reason for the change.

If the physician's new charge exceeds the upper limit of the Prevailing Range of Fees in his area, he will be informed that unless altered, the change will result in the loss of his Participating Status.

Concerning liaison with physicians:

Blue Shield acknowledges the responsibility to maintain active liaison with medical review committees or other appropriate physician organizations on a reciprocal basis. Such liaison is designated to 1) review specific cases concerning Blue Shield's determination of reasonable fees; 2) provide current information on changing methods of practice, especially with respect to charges for new procedures; 3) assist in handling problems of mutual interest to physicians and Blue Shield; and 4) assist and coordinate in the evaluation of any Blue Shield utilization studies relating to medical care and costs.

The Blue Shield Board of Directors has also approved modifications and improvements in Blue Shield coverage as recommended by the Ad Hoc Committee.

This program provides for: 1) adjustments in Blue Shield's basic program; 2) major additional benefits such as home and office calls and drugs.

Concerning Part I and Benefit Adjustments:

Most contract exclusions are eliminated and several Blue Shield riders are incorporated in a new basic package:

- All generally accepted surgical procedures will be covered including inpatient dental surgery when a concurrent hazardous medical condition exists which makes inpatient dental care necessary.
- Also covered is the correction of congenital anomalies and conditions resulting from accidental injuries or traumatic scars.
- In radiological therapy, benefits are extended to other than malignant conditions and without present administrative limitation on the number of treatments.
- Most maternity services, including pre and post natal care, are covered without a waiting period.
- Unlimited number of days care for general medical conditions, including physiatrical care in rehabilitation institutions.
- Additional medical care benefits will provide pediatric examination of newborn and inpatient psychiatric coverage.
- Extend care for pulmonary tuberculosis and mental conditions from 30 to 45 days, with a 90-day benefit renewal period.
- Outpatient and office psychiatric services provided according to the present rider with simplified co-payment provisions.
- Benefits for consultations expanded to include all inpatient consultations according to generally accepted standards of medical practice — with no member liability.

- Emergency first aid will be subject to a $15 maximum allowance available to one or more physicians for initial examination and treatment and with a waiver of the 24-hour limitation for this service.
- Technical surgical assistance: when required for major surgery and services of interns, residents or house officers are unavailable.

Concerning Part II and Major Additional Benefits:

- Home and office medical care will be offered as a rider, and will be available for regular visits in the physician's office, patient's home and hospital outpatient department.
- Prepaid prescription drugs will be made available on a co-payment or deductible basis.

In approving the home and office program, Michigan Blue Shield recognized that most professional services are rendered outside of hospital and bed patient environment. Most physician bills, in terms of dollar volume as well as number, are a result of out-of-hospital services. There are many indications also that adequate benefit protection for out-of-hospital services will help to deter unnecessary in-hospital utilization.

The program approved by the Blue Shield Board will allow for payment of these services on the same basis as described previously under the Variable Fee Program that is tied to the customary and prevailing criteria. In addition, Blue Shield Programs as approved will require certain co-payments on the part of the Blue Shield subscriber.

It may also be noteworthy that home and office calls are not novel in American health care coverage.

About 25 other Blue Shield Plans offer this coverage; an estimated 10 million persons are covered through commercial insurance companies; home and office benefits are available in Michigan to approximately one million persons through the Medicare and Medicaid programs, and through Blue Shield's master medical program.

As to drug coverage, some 29 percent of the civilian population, representing 53.2 millions, had coverage for prescription drugs outside the hospital.

In Michigan, it is and has been one of the most conspicuous gaps in Blue Shield coverage. A survey of key management people in Blue Shield groups indicated such coverage as one of the highest priority benefit needs.

The program covers legend drugs only — such drugs being defined as any medical substance, the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."

When services are provided by a non-participating pharmacist in Michigan, the benefit will be limited to 75 percent.

Blue Shield's Board of Directors considered a preventive care program, including well baby care, physical examinations and eye refractions.

The Board agreed that an active involvement in the combined specifics of preventive care was validly within the scope of Blue Shield's interest and that specific programs should be developed and refined for future consideration. It was desired, however, to delay specific actions at least until the implementation process was begun with respect to other program revisions and additions.

IV. What Comes Now

We live in a testing period for the continuation of the private sector and Michigan Blue Shield must continue to demonstrate that it has the capacity and experience to make it unnecessary for government to extend its involvement in the physician-patient relationship.

Michigan Blue Shield must also continue to demonstrate that it can and must work cooperatively with physicians in developing utilization review techniques.

Recognizing that momentous changes are taking place in the field of medical economics, Michigan Blue Shield is determined to meet and anticipate the challenges of change.

The variable fee, extended benefit home, office and drug programs are Blue Shield's 1967 challenges to those who buy medical service and those who provide it.

Michigan Blue Shield is convinced that these programs will provide equity to the physician and to the subscriber.

Significantly, the programs are completely different from any Blue Shield has ever provided.

There are no fee schedules.

The payment level to physicians is not tied to the subscriber's income.

The scope of benefits is attuned to real medical needs and the cost of these needs.

The programs are flexible. They have been designed in a manner to be an effective, ready response to government alternatives.

Obviously, these matters cannot be effectuated overnight, even though some industries want such benefits immediately. The steel industry has an August 1, 1967, effective date in its contract with labor which was negotiated on September 5, 1965.

Program adjustments may be necessary and there must be more meetings with physicians to explore fine detail.

Exact targets are being worked out and they will be communicated to the medical profession as soon as they are formalized.

We must also secure the approval of the Michigan State Department of Insurance before the programs can be offered.

In a broad but vital sense, the destiny of medical economics is in the hands of the physician.

He has the capacity to control a large part of its future. If there is no prudent self-control, then alternatives will prevail.

It is important enough to restate that the new variable fee program has many payment characteristics which reflect the expressed desires of the medical profession. These characteristics, however, generate a substantial uneasiness on the part of the consumer concerned with higher physician charges.

Concerning physician participation — the economic deterrents to participation have been eliminated since the payment technique will involve "customary" and "prevailing" concepts.

The program has been developed to pay an optimum level of physicians' charges. Actually, there seems to be little or no reason not to participate fully.

We believe that most aspects of the Blue Shield program presented here the physician will like. Some he will not like — and that goes for the public, too.

Michigan Blue Shield has taken an aggressive approach to the realities of medical economics. We think the approach, if successful, will decide whether Blue Shield lives or dies.

We think this instrument is the most effective program Blue Shield could develop in the current environment.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, Robert E. Rice, MD, Chairman, stated, "This report is essentially in two parts. The first part is a report of the activities of the organization for the past year. The second part is a presentation of the revision in the health care programs which has culminated in a new fee and benefit program.

"The Reference Committee recommends these reports to you. We would especially urge each doctor to familiarize himself with the various aspects of the new program as proposed.

"Attention is called to a revision in which the last sentence on page 11 of the Michigan Blue Shield New Fee

and Benefit Program, which states that there will be no per-case participation, has been deleted. Blue Shield intends to permit per-case participation to continue.

"At the time it was printed it was said there would not be any per-case participation; but apparently there was rethinking of this, and so that was reversed. This portion should be deleted from the report."

The Committee recommended acceptance of these reports for information.

THE HOUSE adopted the report of the Reference Committee.

12-b. Treasurer's Report—John R. Ylvisaker, MD

(The following report was presented to the Delegates in printed form. For Doctor Ylvisaker's verbal comments, please see Item 13, Remarks of Council Chairman.)

I have recommended to the MSMS an aggressive revision of management of the assets of the Society. I feel such a revision is essential to accomplish the following objectives:

1. An equitable apportionment of actual current costs of operation only to current dues-paying members.
2. An orderly reduction of debt as a calculated budget item on a sound basis of amortization.
3. The establishment of a specified capital reserve to protect the Society against unforeseen emergencies as well as anticipated cash needs.
4. The utilization of cash resources to achieve the maximum income potential possible at all times.
5. The provision of funds and the establishment of investment policies which will protect the Society against inflationary trends so as to minimize the need for assessments, dues increases, and borrowings not properly programmed.
6. The establishment of a growth fund whose income may provide markedly increased service to the medical profession of the State of Michigan in the future.

I feel these objectives can be accomplished by the adoption of the basic recommendations in this report. I submit this report to you for your detailed consideration and sincerely hope you will support the adoption of the recommendations at the 1967 meeting of the House of Delegates.

This report is concerned primarily with a revision of MSMS asset management together with the establishment of some basic policies of investment administration. The report is divided into two parts:

I. A summary of present policies and financial data pertinent to the recommendations of Part II.

II. A presentation of recommendations for revision of asset management.

PART I

A. Present policies:

1. Capital and/or operating reserve — no concrete policy but approximately $100,000 has been maintained in various fixed-dollar interest-bearing investment vehicles.
2. MSMS headquarters building — no concrete policy but generally has been financed by cash plus an annual variable draw or borrowing against a $230,000 Michigan National Bank line of credit at an interest rate usually ½% over prime (recently ¾ to 1¼% over prime rate).
3. Annual operating expenses — paid out of current income until exhausted in late fall, then out of progressive borrowing against Michigan National Bank line of credit to maximum in mid-winter, with succeeding progressive reduction of loan amounts on receipt of dues income in the spring. Approximately $40,000 per year has been allocated to year-by-year reduction of the line of credit borrowing. Estimated borrowing needs for 1967-1968 are $200,000.
4. Investment:
   a. Current income — applied to current expenses and to reduction of Michigan National Bank loans to achieve savings on loan interest.
   b. Reserve funds — invested in fixed-dollar assets such as savings accounts, government bonds, and certificates of deposit but not in growth instruments such as stock.
   c. Authority — previously vested in the Treasurer, more or less by tradition, subject to review by the Finance Committee of MSMS Council.

B. Financial data:

1. Present status:

a. Assets:

1) Invested funds		$224,000
less Burns obligation and budget requirements		100,000
reserve funds		$124,000
2) Fixed assets — MSMS headquarters building		
Furnishings and equipment		$ 87,520
Land and building — cost	682,000	
— estimated value		1,000,000

b. Budgeted allocations to building

Taxes	$ 18,000	
Insurance	2,600	
Interest	4,000	
Equity	40,000	
Total		$64,600

c. Interest income:

Original estimate	$ 4,000
Current estimate	7,000

2. Revision of asset management to include mortgage financing of MSMS headquarters:

a. Mortgage money allocations:

1) To capital reserve		$100,000
2) To operating or current expense account		200,000
3) To managed investment fund		balance
	assume	350,000
		$650,000

b. Effect of $650,000 mortgage on costs (30 years at 6%)

Taxes	$ 18,000
Insurance	2,600
Mortgage servicing	46,800
	$ 67,400

c. Effect of $650,000 mortgage on income:

1) Capital reserve	
$124,000 invested in high-yield growth securities — growth + 5% div.	$6,200
100,000 invested in 5½% CD	5,500
2) Average current cash reserve	
$200,000 invested in 30 to 90 day 5% CD	10,000
3) Managed investment fund	
$350,000 invested in balanced portfolio — growth + 3% div.	10,500
	32,200
present estimated interest	7,000
Increase over budget	$25,200

Comments:

1. Budget at present provides approximately $65,000 to service taxes, insurance, interest and equity payments for the headquarters building and could easily accommodate a $70,000 amount.
2. Revision of asset management with mortgaging will provide an increased income of $25,000 based on the

most conservative investment policies. In addition, it will provide a growth potential on approximately $475,000 if a $650,000 mortgage is assumed.

3. Illustrations of mortgage servicing needs:

Mortgage	*Interest*	*Term*	*Annual Payment*
$700,000	6%	30 yr.	$ 50,400
700,000	6¼%	30 yr.	51,730
650,000	6%	30 yr.	46,800
650,000	6¼%	30 yr.	48,035
650,000	6%	25 yr.	50,310
650,000	6¼%	25 yr.	51,480
600,000	6%	25 yr.	46,440
600,000	6¼%	25 yr.	47,520

(Add $20,600 tax and insurance cost to annual payment to obtain total cost of servicing building when mortgaged.)

PART II — Recommendations for Revision of Asset Management

Recommendation 1: That a Capital Reserve Fund be established with the following provisions:

a. Amount — the sum of

   1) the accumulated depreciation of furnishings and equipment plus 10%;

   2) 10% of the appraisal (or replacement) cost of the MSMS headquarters building;

   3) Two months operating expense of MSMS.

b. Management:

   1) General investment policy

      a) Minimum of $100,000 to be invested in fixed-dollar assets with maximum rate of return available.

      b) Balance of fund to be invested in high-grade negotiable securities to provide income and growth.

      c) Income of the fund to be re-invested or to accumulate after payment of expenses if any.

   2) Authority

      a) Investment to be accomplished under the direction of five managing trustees, including the Treasurer, the Chairman of the Finance Committee, and an investment counselor appointed by The Council and approved and accepted by the Treasurer and the Finance Committee Chairman, and two members appointed by The Council.

Recommendation 2: That the MSMS headquarters building be mortgaged with the following provisions:

a. That the mortgage amount be no less than $600,000 and no greater than $700,000.

b. That the term, interest rate, and amount of the mortgage shall be negotiated by the MSMS Treasurer but that the annual servicing cost of the mortgage plus the cost of taxes and insurance shall not exceed $70,000.

c. That other conditions shall be negotiated by the Treasurer to provide the least cost to MSMS in commitment fees and/or full or partial prepayment privileges.

Recommendation 3: That the proceeds from the aforesaid mortgage transaction be allocated as follows:

a. An appropriate amount to the capital reserve fund to provide the total requisite amount when added to present available reserve funds.

b. A second amount of $200,000 to the current operating expense account to provide adequate operating funds until 1968 dues are received, with the provision that any balance remaining at that time be added to the managed investment fund to be established.

c. The balance of the mortgage proceeds to a managed investment fund to be established.

Recommendation 4: That a managed investment fund be established with designated proceeds from the aforesaid mortgage transaction with the following provisions:

a. Authority for investment and re-investment of this fund as well as for management of all its assets including purchase, sale, or trade shall be vested in the five trustees established for the management of the capital reserve funds.

b. Investment policy shall be at the discretion of the designated trustees to provide a balanced portfolio of stocks, bonds, real estate, or other bona fide investment vehicles for maximum income, growth and stability.

c. Allocation of income shall be primarily to servicing MSMS, its component societies, or its members for other than ordinary operating expenses as directed by The Council. Any unused balance shall be re-invested annually except for expenses of fund management which shall be serviced from fund income. Such expenses shall include a per diem or per hour consulting fee for the appointed investment counselor.

THE REFERENCE COMMITTEE on Ways and Means, S. N. Kelso, MD, Chairman, reported as follows:

"This Reference Committee approves in principle the recommendations of the Treasurer's report and also the recommendations of the Committee to Study the Financial Structure of MSMS. However, because of the newer concept of financing proposed, the Reference Committee feels that the members of the House of Delegates should have more time to better acquaint themselves with the proposed changes.

"Your Reference Committee recommends that a committee of the House of Delegates be appointed to further consider this proposal and further acquaint the county medical societies with the intent and implications of this proposal. The committee to be instructed to report back to the 1968 House of Delegates."

THE HOUSE amended the report so that it read, "This Reference Committee approves in principle the recommendations of the Treasurer's Report and also the recommendations of the Committee to Study the Financial Structure of MSMS." The House then adopted the report as amended.

REPORTS OF THE COUNCIL

13. Remarks of Council Chairman — Robert J. Mason, MD

The Annual Report of The Council in your Handbook outlines the major areas of concern and action which were taken by The Council in exercising its leadership responsibilities. My remarks today will include the pertinent actions of The Council since the printing of its report. In addition, I will make some personal observations, and finally will call upon MSMS Treasurer John Ylvisaker for some comments.

As you are aware, the full Council meets eight times a year in regular session and in special session as necessary.

The Council reviews minutes of all committees, reviews the annual reports of all committees, and takes definitive action on these reports. Because The Council is a large group and many matters come before it requiring detailed study, The Council is organized with three standing Committtees — Finance, with Robert Whiteley, MD, Chairman; County Societies, with Harold Hiscock, MD, as Chairman; and Publication, with Brooker Masters, MD, as Chairman. These Committees serve as pre-study committees which make recommendations to The Council on the items referred to them. I only outline this to emphasize the point that detailed study and deliberation is given to every action of The Council.

The Council is also sensitive to the concerns of the individual members of MSMS, the component societies and specialty organizations composed of MSMS members. As evidence of this, let me point out that in response to the strong views advanced by several component medical societies and specialty groups which advocated the rescinding of 1966 Resolution 22, "Definition of a Specialist," The Council undertook a review of the necessity for this definition of a specialist and concluded that HEW *did* require specialty designation, and that the most fair and reasonable criteria can and properly should be made by physicians. The Council reaffirmed its belief that the 1966 House of Delegates' "Definition of a Specialist" is a practical and reasonable definition, and authorized greater dissemination of this information.

In another instance, The Council received several resolutions from component societies and specialty groups urging reconsideration of the Utilization Review Manual and calling for a special session of the House of Delegates to reconsider its action in 1966 disapproving the Manual.

The Council noted that the Bylaws provide mechanisms for the calling of a special session and decided to take no initiative in such a call. However, The Council believed that the concern expressed by a significant number of the members warranted action, and it therefore referred the Manual back to committee for re-study and evaluation in light of the actions and directions of the 1966 House of Delegates. I think this is evidence of the responsiveness of The Council to your interests and concerns.

In your printed report you will note that The Council elected Kenneth H. Johnson, MD, of Lansing, as the new MSMS Secretary to fill the unexpired term of O. B. McGillicuddy, MD. Dr. Johnson brings a great deal of experience to The Council, having held many leadership positions in the state medical organization in the past, and we look forward to his continued service to organized medicine.

I need not outline for you the many continuing problems that are facing medicine. The House of Delegates sets the policy for the ensuing year and The Council implements these policies on a month-to-month basis. You are again facing serious problems at this meeting.

You and The Council are both concerned with the adequacy of funds to do the job. Within the past year we have had the privilege of having with us in the capacity of Treasurer a dynamic young man with great financial background who has made a serious and knowledgeable study of the management of the MSMS assets.

Traditionally at this time the Chairman of the Finance Committee is called upon to report the status of the finances of MSMS; but since this is detailed for you in The Council's report, and because the triennial Committee on Financial Structures, chaired by James D. Fryfogle, MD, has made a 1967 study as well as a 1966 study, The Council believes that as a means of saving time this portion of the supplemental report of The Council can be dispensed with this year. The results of Treasurer Ylvisaker's study, I believe, are of great importance to the future of MSMS.

I would like to call upon Dr. Ylvisaker now to say a few words to you about his recommendations for the management of the MSMS assets in the future.

Dr. Ylvisaker is Vice Chief of the Division of General Surgery at St. Joseph's Hospital, Pontiac; a member of the Board of Directors of the Oakland County Medical Society (and its financial adviser); a member of the Board of Directors of the Birmingham-Bloomfield Banks, and a successful real estate developer. Doctor Ylvisaker.

JOHN R. YLVISAKER, MD: The printed report is included in your Handbook, and I think you have sufficient access to it to review it carefully.

First of all, in approaching this money management of the Society, I do not mean to imply in any sense that we are in an unsound position or condition. Inasmuch as Dr. Whiteley is not here, I would like to make the simple statement that it is only because we are in a sound condition financially that it is even possible to consider any form of asset management.

There has been a great deal of work done in the recent past in attempting to reduce our cash outlays, to budget items that will provide some stability to the management of our cash resources, and I think it has been done very well and it is being followed very closely by the Finance Committee.

I want to talk to you fairly informally and extemporaneously on how it came about that I determined, at least for myself, that we had some necessity for a revision of asset management, as controversial as it might seem.

I took the job of Treasurer of the Society with a little reluctance. I inquired extensively beforehand what the nature of the job was, and whether it would be a matter of spinning wheels and being a figurehead or whether it would give me an opportunity to make some contribution.

When I came into the job, naturally I floundered just like anybody else would, because there is a complexity to what has been done in the past that is a little difficult to unravel just by the nature of the organization and the manner in which it does its business.

I first went to the various authoritative individuals to find out what the obligations of my new position were, and it was difficult to find any firm delineation of what my duties were. This disturbed me to some degree. I then tried to determine what formal line of command was involved in the determination of how our money was spent; and except for the average expenses, again there is some lack of clarity in this regard. Please don't interpret this as any kind of criticism of any nature at all. I don't mean it in that way. I only mean it in the sense that I would like to establish certain guidelines.

I tried to determine what policies had been followed in the past, and in most areas there were no clear-cut policies that were consistently followed on a year-to-year basis. There was a fairly informal method of approach, but nothing specifically delineated.

I wanted to determine whether we had a sufficient capital reserve to handle contingencies that might occur, and I found that we had some cash resources in the amount of about $100,000 that were invested in various vehicles, but they were not returning to the Society a maximum rate of interest as we could achieve it in our present money market, and that these funds had been invested on the authority of the Treasurer, but following the death of the previous Treasurer there was no clear-cut authority established.

I tried to determine how we were performing in relationship to our annual expense items, and I found that The Council very wisely had decided that they would save on interest by borrowing against a line of credit so that in the early part of the year, when the dues income came in and we would have a surplus of cash, we would pay off any borrowings from the previous year. And as we went through the year toward fall, when we would have exhausted our cash resources and our dues income, we would then begin to borrow; and by the end of November, which is the end of our fiscal year, we would be at a point of deficit financing for operation of somewhere around $170,000 to $200,000; but in December and January, which would be our maximum borrowing months, we would be beyond this point. At the time I came in we were borrowing against a line of credit of $230,000.

I felt when I looked at what had happened in the centennial year — for instance, when an unusual expense occurred, when we had no reserve to meet that expense, when we had to revise our budgetary apportionment of income considerably, we were not retiring debt on an amortized basis, in the sense that we really ought to exhaust the debt that we had basically incurred by the building of the headquarters.

So, as you can see, in going through this I felt I saw certain problem areas. One of the problem areas, in addition to this, was that we had no inflationary hedge built up; we had no contingency reserve; we had no planned debt retirement, and we were vulnerable to the daily money market to an extent that I would prefer not to be.

I felt for all of these reasons there was a vulnerability on the part of the Society for additional assessments or possibly additional dues increases that had raised such a hubbub in the past. I am not sure what the experience is in your various county societies, but the experience in ours is that we have a great deal of resistance to the dues increases and the assessments because many of the members do not feel they have any service returned to them. This is not true, of course, but it is their feeling, and we have had resignations from our society. I think there is a tendency in this direction to try to get out of paying State Society dues.

I therefore went into this program to try to determine how we could accomplish certain objectives. The objectives are stated on the first page of your report. I want to read them briefly.

1 — I felt we should have an equitable apportionment of actual current costs of operation only to current dues-paying members. I did not feel it was in the province of our responsibility — the 1967 members paying for a building that was going to be used by the 1980 members.

2 — An orderly reduction of debt as a calculated budget item on a sound basis of amortization. Instead of coming to the end of the year and saying we have so much money left at the end of the year, now we will apply this to the debt retirement or whatever else it happens to be, but actually somehing that would be planned.

3 — The establishment of a specified capital reserve to protect the Society against unforeseen emergencies as well as anticipated cash needs — again attempting to avoid any vulnerability in the area of new assessments or new dues increases.

4 — The utilization of cash resources to achieve the maximum income potential possible at all times.

5 — The provision of funds and the establishment of investment policies which will protect the Society against inflationary trends so as to minimize the need for assessments, dues increases, and borrowings not properly programmed.

6 — An area which I think there is probably more question on than almost anything else: The establishment of a growth fund whose income may provide markedly increased service to the medical profession of the State of Michigan in the future.

The only asset that we had which I could turn to to augment the capital reserve we had, to get us out of the deficit financing position we were in, to provide both contingency reserve and an operating reserve, was the building, which we in essence are borrowing against already.

I realized that this building was worth considerably more than what it cost. It cost us in the neighborhood of total assets of about $685,000, and with informal appraisals we have determined it is probably worth in the vicinity of $1 million or maybe more. It is a mortgageable asset, an asset which by conventional financial thinking could become the source of funds to provide for necessities of the Society. It was being depreciated over a 50-year period. It is a 50-year building, a good building, one we ought to be proud of; but at the same time there is no reason why it should not be paid for over a much longer period of time than the 10 to 15 years over which we are programming this.

So, I investigated with the Michigan National Bank particularly, since they have been our banking friends for many years, as to how they would view this. Before doing this, I discussed it at length with many financial advisers, all of whom thought that the idea was sound. The Michigan National Bank felt that it was sound, to the extent that they would advance us whatever money we should need — and they mentioned a figure up to $750,000.

In the financing of a building like this, as I am sure you are aware in financing your own home, there are certain pitfalls to avoid. One of them is the costs of financing it. We have a commitment from them that there will be no fees to get into a mortgage. It will really be in a sense putting on paper something we have had before, and obtaining additional monies on the same basis but on a more sound basis than we have had before — at least a more properly apportioned basis.

Then I wanted to know how they would view prepayment privileges, because when you get into a mortgage like this a bank would like to lock you in at a specific rate of interest. Since we are dealing in a fairly high money market at the present time, first of all I wanted to find out if we were going to get the lowest interest rate to possibly be achieved, and they have guaranteed me they would.

On a daily basis, of course, the money market changes. They were talking in terms of 6 and 6.5 per cent. Right now the market is 6.75 to 7.5 per cent. I think we can still achieve 6.25 per cent.

They also promised that, since they had loaned to us on the basis of this repayment schedule we have had before, they would not charge any penalty for full prepayment privileges. In other words — and this was discussed fully with them — at any point that the interest rates dropped in the money market, we in essence would pay this mortgage off and get a new mortgage at no cost, at the lower rate of interest; but we on the other hand would be locking them in at a top interest rate. They could not move the interest rate up on us, but because of our valued relationship they would allow us to go down from this point at a time in the future. That was pretty darned good, because it provides an avenue of exit in other situations as well.

If we did this, what would happen to our budget? This is an important thing for you to review, and I tried to delineate how this might affect the budget. I found that we have again sort of informally designated approximately $65,000 a year for the taxes, the interest, the equity payments on this building. So, I tried to stay within this budget planning of $65,000 or a maximum of $70,000 for servicing the needs of the building.

I felt that, depending on the interest rate and the term of the mortgage, we should probably try to draw down as much money as we could, first of all to build up capital reserve to a point where it could handle contingencies, and I felt we ought to have $225,000 to $250,000 in a capital reserve fund.

I also felt we ought to obtain sufficient money to get us out of the deficit financing position we have been in, which would be approximately another $200,000 to cover the anticipated borrowing needs of this year and, having done this, there would be a balance left.

Of course we could stop at this point and achieve these two major purposes with a lower mortgage, and this might be advisable in the eyes of some people; and having achieved this, and having money available to use on a reserve basis, have a lower interest payment and a smaller equity payment and thereby reduce our budget needs and possibly increase our services on that basis because we have more income coming, or reduce our dues, or all kinds of things you can think of doing.

But I didn't feel this was primarily the purpose of this. The purpose of this was to safeguard the Society, to shepherd its funds properly, to provide for the future as well as we could; and additionally, if it were possible, to provide more overt service to the component members of the Society and to the component societies so that the value of the State Society would always be more apparent to them.

I felt that the establishment of a managed investment fund could accomplish this because it should grow without any problem at all if the economy grows. It may contract if the economy contracts. Its purchasing value, however, in relationship to the economy, should remain relatively stable.

I felt that this would be well within the circumscription of our aims and societies to improve medicine and medical care and medical service in the State.

Now, I recognize fully that there is a cost of doing business. I don't want you to be misled here by thinking we can do this and achieve the extra $25,000 of cash flow without a cost, because if you borrow money at 6.75 per cent and if you invest it and retrieve something in the range of 4 per cent average, you have a 2.25 per cent point spread that you are going to pay for.

The point is that this 2.25 per cent point spread is still handled within our budget, and without extending our budget it produces additional cash flow above what our normal budget income amounts are; and it accomplishes an inflationary hedge that is very difficult to purchase in any other way except as we have done inadvertently with our building.

However, our building isn't going to be a constant inflationary hedge. We are probably nearly at a peak of the utilization of our building as an inflationary hedge. Why? The building is getting older and there is a point at which real estate appreciates with the economy, and then a point at which the economy takes off from the value of the building or the appreciation; and the building begins to depreciate and you begin to get a spread once again, where you cannot retrieve this kind of capital. I feel that we are in a fairly optimum period for using our assets as well and as judiciously as we possibly can.

There has been a fair amount of questioning about how this would affect our tax-exempt status. I have inquired of my own attorneys; I have tried to investigate this on my own; I have talked to Mr. Kerr, our Legal Counsel, and last night I had a long talk with Mr. Dodd. I know in discussing with Mr. Dodd that he has a more conservative approach than I have and than many of us may, but I particularly wanted to know from him whether there is anything in the Internal Revenue laws at the present time that we would be in conflict with by doing this. The answer — and I will certainly give him the opportunity later on to answer this himself — the answer was No.

However, the point was raised that *National Geographic Magazine* and other organizations on a tax-exempt basis are being watched very carefully by the Internal Revenue Service and will probably be subject to taxes on non-related income at some point in the future.

But we can't second-guess the future to that extent, and we are already in this area with the income from the *Journal*. So, we are not exchanging our position in this regard at all.

I fully believe that if this should occur, if this possibility should come into reality in the future, there is no reason that we can't balance our portfolio in such a way as to get proper tax shelters, to minimize the impact of taxes. In addition to this, if worst came to worst, there would be the possibility of either paying off the mortgage and getting out of the thing because we have full prepayment privileges, or turning this money into a foundation which would have the same purposes for which the management investment fund would be set up, and thereby achieving tax-exempt status.

I would sincerely request that you review this with an open mind and that you not try to project your own personal philosophies of managing your own assets into a program that is not designed for an individual but that is designed for an organization with the goals that we have and with the responsibilities that we have.

Thank you.

ROBERT J. MASON, MD: Thank you, Dr. Ylvisaker.

The Treasurer's report is in your Handbook for your serious consideration. It has been approved by the Finance Committee, whose recommendations were approved by The Council for reference to the House of Delegates. The House of Delegates Committee on Financial Structure has also studied the Treasurer's report and is making a recommendation to you also. This is contained in your Handbook.

And now, gentlemen, for my personal comments.

In all likelihood you will have reviewed by now the *Where We Stand* publication — a workbook prepared by our Research and Development Department. Its purpose, as you know, was to point to the many perspectives of today's changing health scene. As it does so, it tries to relate these views to our profession's desire to remain in a decision-making position.

Rather than attempting to dictate policy, this workbook suggests areas where new policies might proliferate to the advantage of those whom we serve as well as ourselves.

The development of these policies is the prerogative of the House of Delegates. But perhaps you will note, as did I, that repeatedly the questions raised, although basic, were complex and required facts and opinions which we do not have at firsthand — facts and opinions which we must have if we are to confidently take a policy stand.

For that reason, I particularly invite to your attention the discussion under Chapter 14 on pages 55 and 56 of the *Where We Stand* publication. If such an Institute could merely clarify, evaluate and relate to our profession, the research and distribution of health care *presently being done in Michigan by others*, it would be rendering a service of great value. At the same time this Institute also might serve our State Government as an unbiased source for our State Legislative, Executive and Judicial Branches to use for reference purposes.

I commend this for your serious consideration.

The Council is dedicated to serving MSMS membership and members of The Council have given unstintingly of their time and knowledge in administering the affairs of MSMS in the public interest. I personally thank each and every one for their devotion to duty.

I would be remiss in closing my remarks if I did not extol the excellence of your professional staff which labors so untiringly in our behalf. The exemplary performance of Mr. Brenneman and Mr. Tryloff I can personally commend. I should also like to praise the untiring efforts of the other executives who are growing in stature and awareness of the problems facing medicine and are outstanding in their devotion to duty.

I should like to praise the secretaries on our staff who perform the detailed execution of duties which make our organization operate so efficiently and who spend so many hours in uncompensated service, as witness the performance of duties during this annual activity of 16-hour days.

With your policy direction, good leadership and a fine staff, The Council shall continue to be a driving force in implementing the policy directions set for it by this House of Delegates.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, felt that recognition should be made of the abundance of work accomplished by The Council and commendations extended to each of its members.

Through three pre-study standing committees The Council's efficiency in responding to members' interests and concerns is enhanced.

Attention was called to a workbook entitled, "Where We Stand," developed to point out perspectives of today's changing health scene. The Reference Committee commended it to the perusal and consideration of each delegate.

THE HOUSE adopted the report of the Reference Committee.

14. Annual Report of The Council

PART I

Report of Council Activities

This section of the report contains a brief review of the activities and actions of The Council covering the period from September 1966 to July 1967.

Minutes of the regular meetings of The Council are distributed to component medical societies and members of the House of Delegates. In addition, abstracts of Council actions appear in *Michigan Medicine*. For this reason, the details of Council actions and decisions are not outlined in this review. Instead, The Council wishes to point to a few of the major achievements and problems in a general way.

Liaison with Governmental Agencies and Medical Programs. MSMS has been directly concerned in many governmental programs. Primary interest has been devoted to the development of rules, regulations and operating procedures of Medicare (Title XVIII) and Medicaid (Title XIX), because of their immediate importance to physicians and medical practice. Through direct liaison at the Council level, as well as committee and staff level, MSMS has been influential in helping to shape the implementation of Medicare and Medicaid.

A major liaison role was played by the Committee on Governmental Medical Care Programs, which has detailed its work in its Annual Report.

Since the finalization of that report, important action at both the Federal and State level has occurred.

The Committee had been negotiating with the Department of the Army seeking payment to physicians who participate in CHAMPUS (Civilian Health and Medical Program of the Uniform Services), on a payment concept of "usual, customary and reasonable" as developed by the Social Security Administration in implementing Medicare and Medicaid. These negotiations had been unfruitful until recently. The administrators of the CHAMPUS Program have now agreed to our views and, at the expiration of our contract on October 31, 1967, reimbursement to physicians will be made in the same manner as in Medicare and Medicaid. Similarly, the Committee was in negotiation with the Veterans Administration seeking the payment of usual, customary and reasonable fees for physicians participating in the VA Hometown Care Program. This matter was not resolved to the satisfaction of MSMS and, therefore, the VA has not entered into a contract with MSMS and has advised MSMS that the VA will set maximum fee levels.

The most far-reaching program since Medicare - Medicaid is the federal Comprehensive Health Care Planning Law (PL 89-749).

In August, Governor Romney issued an Executive Order creating the Comprehensive State Health Planning Commission which will be located within the Executive Office. This newly established Commission closely parallels, in basic concept, recommendations previously made to the Executive Office by The Council and the Committee advocating that a plan-for-planning group be set up under the Executive Office to formulate plans to be submitted to the Surgeon General for the operation of a state comprehensive planning agency in 1968.

MSMS has been involved in the important plans for implementation of the Heart-Cancer-Stroke Program through the Michiagn Association of Regional Medical Plans. MSMS representative Don Marshall, MD, is a member of the Board. D. Bonta Hiscoe, MD, is his alternate. A report on these plans will be found in the Annual Report of the Education Liaison Committee. Briefly, however, the MARMP plan has been approved in Washington and a grant authorized exceeding one million dollars.

MSMS Guidelines for Screening Procedures. For many years The Council has offered general guidelines to component medical societies re participation in local screening programs. Recently, however, because of increasing requests for screening participation, component societies have asked for more specific guidelines from MSMS.

As a result of an intensive study of national, state and local guidelines, The Council adopted the following Guidelines and recommended them to component societies for consideration:

Guidelines for Health Screening Tests*

The Michigan State Medical Society endorses and supports health screening programs as a potentially useful medical tool in the field of preventive medicine and early diagnosis. The Society believes these programs, as an investigative procedure for both the public and the profession and as a means for early detection of disease, may be used beneficially for the improvement of health.

It must be recognized, however, that screening programs, as an adjunct in diagnosis of disease, are part of the practice of medicine and that active physician participation is mandatory. There must be adequate safeguards to protect the patient and the medical profession from unethical or illegal practices.

In order that these programs may "serve humanity" and at costs "commensurate with the services rendered," it is recommended:

1. That the objective of such programs be:

   To detect abnormalities at an early stage so that definitive diagnosis and effective treatment can be initiated. To educate the public to the value of preventive medicine and to the advantage of having a personal physician.

   To collect and evaluate data pertinent to the changing trends of disease.

2. That the rights and responsibilities of the participants in these programs be clearly defined:
   The sponsoring agency or agencies should plan, organize and finance the program; publicize it to the public; maintain adequate records of the individual screenee and of the total results. In programs sponsored by multiple agencies prior coordination and agreement as to responsibility and reporting procedures are essential.

   The sponsoring agency or agencies should seek and obtain medical guidance at the initiation of the program and follow medical direction until its completion.

   The physician, or physicians, is responsible, legally and ethically, for all the medical practices. It is his privilege and responsibility to submit the plans at an early date to his county medical society and to obtain its approval before initiating the program.

   The physician should be responsible for overall supervision of the tests, the medical records, evaluation of the program, and for reports of tests which must be submitted to the screenee's personal physician of its findings. If, in the opinion of the physician in charge of screening, the screenee is to be advised of the results, this information shall be limited to a statement as to whether the tests were normal or abnormal. No diagnosis or implication of diagnosis shall be given to the screenee.

   The screenee must participate on a voluntary basis and his consent must be obtained for release of his records. It shall be his responsibility to seek treatment when indicated.

   The Medical Society on request shall review and advise relative to the medical aspects of any proposed program and approve those that meet its criteria. It shall encourage the membership to participate in those programs it has endorsed. It shall receive reports of the results of these programs and disseminate pertinent data to the membership.

3. That the sponsoring agency make available a public accounting of costs; and make no charge to the screenee.

4. That physicians may contribute their services as members of advisory committees of the health agencies or of their Medical Society. However, they should be re-

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* Screening as herein used shall be defined as: "The presumptive identification of unrecognized abnormalities by the application of tests, examination or other procedure."

imbursed for professional participation in screening programs.

5. That the tests be safe, simple to perform, inexpensive and subject to accurate interpretation.
6. That multiphasic screening should be used when feasible.

Definition of a Specialist. In response to strong views advanced by two component medical societies, which advocated the rescinding of 1966 Resolution 22, "Definition of a Specialist," The Council met with representatives of that point of view. As a result of the questions raised re the necessity of designating specialists by the Medicare carrier, The Council appointed an ad hoc committee to study the entire matter.

Its report concluded that HEW did require specialty designation and that the most fair and reasonable criteria can and properly should be made by physicians.

The Council adopted this report, and reaffirmed its belief that the 1966 House of Delegates Definition of a Specialist is a practical and reasonable definition, and authorized greater dissemination of this information.

> DEFINITION OF A SPECIALIST (adopted by the 1966 House of Delegates)
>
> Whereas, Title XVIII and Title XIX of Public Law 89-97 does not clearly state a differentiation between generalist and specialist, and
>
> Whereas, it would be expedient for the House of Delegates rather than the federal government to make such a distinction, therefore be it
>
> RESOLVED: That the House of Delegates adopt the following definition of a specialist:
>
> A specialist shall be a physician
>
> 1) certified by the appropriate specialty board, approved by the Advisory Board for Medical Specialties and by the American Medical Association Council on Medical Education, or
> 2) practicing as a specialist not possessing a specialty board certificate but
>   a) has completed an approved residency in that specialty or has been graduated from medical school before 1945, and
>   b) has had at least four years' experience in a given specialty (including the recognized residency), and
>   c) has at least 60 percent of his practice devoted to a given specialty, and
>   d) is recognized as a specialist by the staff of the hospital in which he practices provided it is an accredited hospital.

Proposed New Blue Shield Contract. Blue Shield began a year ago exploring possible changes in benefits and payment techniques.

MMS gave a brief progress report to The Council at its June 14 meeting on the extended benefit program and variable fee provisions. A full and detailed explanation was presented to The Council on July 14.

After this discussion, The Council adopted the following recommendations for transmission to the Blue Shield Board: 1) In any new contract that may be accepted, the patient should have the right of assignment; 2) that any new contract should continue to provide for the right of physicians to participate on an individual case basis; 3) that individual physician profiles take into consideration the specialty training of the physician; and 4) that the arbitration of fees be handled by Michigan Medical Service and the county medical society. The Council also recommended that the final written report on the variable fee proposal be sent to The Council as well as to component society officers and MSMS delegates as soon as possible.

The MMS Board held a special meeting on August 16, at which time the foregoing recommendations were considered. The Board approved some modifications of the proposed contract including Recommendations 2 and 4 above. The Board believed that the intent of Recommendation 3 already was incorporated in the program and that Recommendation 1 would require a reconsideration of the entire consent judgment.

All the printed data available to The Council has been sent in brochure form to all MSMS members.

This matter will be explained in detail at the MMS Annual Meeting by Blue Shield.

Resignation of MSMS Secretary. The Council accepted with regret the resignation of O. B. McGillicuddy, MD, as MSMS Secretary, in June. The Council made arrangements for a suitable presentation recognizing him for his long record of faithful service to organized medicine.

At its July meeting, The Council elected a Secretary to fill the unexpired term. The individual is now deciding whether or not he will be able to accept the appointment.

Finance. In 1966 The Council adopted a new system of budget development and financial reporting based upon staff recommendations developed with the aid of the Alexander Grant Company, Detroit, Certified Public Accountants. By means of the new managerial procedures, The Council and its Finance Committee are provided with comprehensive financial information showing current status of all budget items and the overall financial position of MSMS.

These procedures, in a full year of operation, have greatly aided in planning expenditures and observing the effective utilization of finances measured against budget projections.

The technical aspects of accounting procedures have been appropriately redesigned and continuing study is being given to the feasibility and desirability of incorporating the use of electronic equipment.

MSMS reserves are $125,000 invested in time certificates and savings accounts. This reserve is retained as a liquid reserve for contingencies. In 1967 investments have been manipulated extensively to achieve the greatest advantage from the changing money market.

On July 1, 1967, MSMS had no outstanding short-term notes. However, as in the past, it will be necessary to reborrow during the closing months of the year and repay in the early months of 1968 when dues income is high.

At the end of fiscal 1961 outstanding notes totaled $200,000.

At the end of fiscal 1962 outstanding notes totaled $150,000.

At the end of fiscal 1963 outstanding notes totaled $125,000.

At the end of fiscal 1964 outstanding notes totaled $100,000.

At the end of fiscal 1965 outstanding notes totaled $170,000*.

At mid-year in 1966, it was anticipated that short-term debt, at the end of the fiscal year, would be $25,000 less than at the end of the previous year.

Actually, however, the outstanding notes approximately equalled the previous year's although the net effect of the Finance Committee's goal was achieved since the cash position of the Society had improved by $25,000. Rather than divert all cash to reduce borrowing, the Society's operating account was left in a sound position at year end. In 1967, we expect to reduce outstanding notes to $130,000 or less.

The 1966 House of Delegates recommended and approved a ten dollar increase in dues which has provided necessary funds to 1) maintain our desired scope of activities, 2) increase MSMS liaison-legislative effort through employment of additional personnel, 3) absorb the increased cost of doing business in areas of supplies and postage, taxes, maintenance, and printing, and 4) increase our ability to reduce our needs for short-term loans.

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* Due to unusual expenses incurred during the celebration of the MSMS Centennial short-term indebtedness was not decreased in 1965.

At the beginning of the year MSMS retained Mr. Warren Huff, former chairman of Michigan State University Board of Trustees, on a consultant basis to aid in liaison with political, legislative and educational leadership, and to work in the field of higher education, particularly as it relates to medical, para-medical and related educational programs and financing.

In July, The Council was informed that Mr. Huff's situation had changed and it then decided that Mr. Huff's six-month contract should not be renewed inasmuch as he was essentially in the full-time employment of another organization.

The Council is now actively seeking an individual to serve as MSMS Assistant Legislative Representative.

The cost of doing business has risen during the report period but the rate of climb has leveled off and it is hoped that modest increases can be accommodated and partially offset by improved purchasing procedures and the continual search for alternative, less expensive, production and mailing methods.

The Council's Finance Committee has provided all desired information to the House of Delegates Committee to Study MSMS Financial Structure, which is for 1967 updating its 1966 report.

The MSMS investment program has been under study and review by Treasurer Ylvisaker and recommendations will be presented to the House in his special report.

Membership. Total membership in MSMS as of June 30 and December 31, from 1935 to 1966:

Year	*June 30*	*December 31*
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1965	7247	7563
1966	7296	7710
1967	7301	

Medical Aid Station at Capitol Building. This successful MSMS project, in cooperation with Ingham County Medical Society physicians, to provide a medical aid station in the Capitol building for members of the Legislature was again operative in 1967. MSMS defrays the expense of a staff nurse and local physicians volunteer to serve in emergencies and take referred calls. The Council once again expresses its appreciation to the Ingham County physicians who participate in this worthwhile service to lawmakers.

Liaison with Specialty Groups. Recognizing an opportunity to be of service to the various organized medical specialty organizations, The Council appointed an ad hoc committee to review these needs and make recommendations to The Council. It is hoped that the Committee can complete its recommendations by September.

Auto Safety Design Commission. In response to 1965 House Resolution 46, The Council appointed an ad hoc committee to seek the creation of an Auto Safety Design Commission. The Committee met with medical directors of the major automobile manufacturers to explore possible approaches. General reaction was that any joint effort would reduce the effectiveness of the individual organizations' productiveness. The Committee finally questioned the influence such a Commission would have since recent federal legislation has led to more engineering talent being devoted to the development of a crashworthy car.

The Council approved the Committee's recommendation and dissolved the Committee with thanks for its efforts.

Communication with MSMS Leadership. In January, The Council approved a two-stage program for communicating with the medical society leadership. The first stage was a series of regional meetings between MSMS officers and staff and component society leaders. The second stage was a group meeting in May in Detroit, called an "Informational Meeting for MSMS Leadership," to brief physicians on the problems facing medicine so they might return to their constituents and make plans for desired action at the September House of Delegates meeting. The guests at the May meeting included Delegates and Alternate Delegates to MSMS.

Both informational programs were well received by component society officers and delegates.

Postgraduate Education

This past year, MSMS improved its postgraduate educational program to continue to carry out a major purpose in the MSMS Constitution, "to maintain programs of scientific education keyed to the constant advancement of the science of medicine and to foster, encourage and coordinate postgraduate educational facilities for the medical profession as a whole."

In this time of unprecedented change in medical knowledge, social concepts and moral values, the educational needs of physicians are great and complex. With this in mind the general format for the 1966 Annual Scientific Session was changed markedly in a conscientious effort to meet these changing needs. Fewer lectures and more round-table discussions were offered, covering a broad range of subjects of interest to every physician and providing ample time for questions and answers. Comments were enthusiastic from the participants and further innovation will be made in the 1967 Annual Session.

During the fall of 1966 and the spring of 1967, MSMS provided postgraduate programs throughout the state, with the exception of the Detroit metropolitan area. These too were changed to give greater value. In addition to the after-dinner evening lecture, more communities added clinical conferences in the afternoon. Patients were presented and visiting professors discussed actual cases. A total of 57 faculty members from Wayne State University and the University of Michigan medical schools traveled 25,300 miles to provide 33 programs in 20 selected centers. Attendance in the Upper Peninsula continued to be extraordinarily high. Statistical details are available in the annual report of the MSMS Committee on Postgraduate Medical Education.

Michigan Medicine, the monthly journal of MSMS, has become one of the finest state medical society publications. Its original scientific articles are outstanding. The many requests for reprints from foundations, other medical journals, medical textbook publishers, pharmaceutical associations and others are an index to the quality of the articles. George H. Lowrey, MD, Ann Arbor, completed his first year as scientific editor in April, 1967. Herbert A. Auer remained as managing editor.

The many conferences sponsored during the year are an important part of the postgraduate activities of the Society. These included the Sixth Annual Conference on Maternal and Perinatal Welfare, the Second Conference on Medical Aspects of High School Sports, the Annual Diet Therapy Conference. Details may be found in annual committee reports.

Relations — Professional, Public, Legislative

This report highlights only some of the major public relations work of the past year as MSMS has sought to inform and influence special selected audiences and the general public. An Annual Report of the Public Relations Committee contains the details.

MSMS Health Careers Mobile. After a successful first year, from September 1965 to September 1966, under the sponsorship of MSMS, the handsome Healthmobile unit was shifted to the sponsorship of the Michigan Health Council and renamed the Health Careers Mobile. MSMS contributed to the financing of the project and MSMS staff assisted in the scheduling, manning and transporting, etc. Many exhibits were changed and new ones added to emphasize the careers appeal. The Health Careers Mobile has traveled to many communities and the response has been enthusiastic from school administrators, teachers and careers counselors and interested parent groups, as well as from the students. The complete schedule is in the PR Committee report, but special mention should be made of the successful spring visitations to three inner-city Detroit high schools, with excellent cooperation from the Detroit Medical Society, and to the summer-long stay on Mackinac Island when it was visited by thousands of Michigan and out-of-state tourists.

Special Education Efforts. Upon the suggestion of the Public Relations Committee, MSMS carried out several statewide educational thrusts with guidance from MSMS scientific committees.

During August and September of 1966, the MSMS effort was in the field of medicine and football. News releases were issued, the cover of *Michigan Medicine* identified the physician as one concerned with the health of the athlete, special radio tapes were issued, and 15 component medical societies received MSMS direction and encouragement to hold conferences for team physicians, coaches and trainers.

During October and November there was a concentration of educational and informational effort re venereal disease control. Again there was a *Michigan Medicine* cover and articles, news releases, a TV news film clip, radio tapes, etc.

December and January were appropriate months to focus the attention of both the doctors and the public on the fact that "Alcoholism is a Treatable Disease." That was the motto for releases to newspapers, radio and television stations, for a *Michigan Medicine* cover, etc.

April and May were officially observed as "Family Life Education Months" and invited considerable public attention to the leadership of MSMS this past year in the field of family life and sex education. MSMS speakers covered major conventions of both parent and youth groups. Aids to teachers were added to the usual PR materials.

The educational thrusts enabled MSMS to utilize the committees and ongoing programming in such areas as radio, newspapers, television, *Michigan Medicine*, etc., to add emphasis to some of the many activities of MSMS members.

Liaison with Component Societies. Practical public relations activities have been suggested throughout the year by the MSMS Public Relations Committee and staff for the component medical societies to consider. During the statewide educational thrusts about sports, venereal disease, alcoholism and family life education, specific how-to-do-it guidance for local work was provided.

While the series of grassroots "CPC" conferences across the state during the spring with component society leaders was not designed specifically to improve public relations alone, each of the programs did provide a seminar session on good public relations ideas.

Liaison with the Michigan Association of the Professions, the Michigan Health Council, and Other Organizations. Considerable time and effort of MSMS officers, committees and staff members enabled MSMS this past year to deepen its good rapport and working relationships with the Michigan Association of the Professions, the Michigan Health Council and other organizations. Once again, both MAP and MHC were helpful in such fields as career recruitment, legislation, etc.

Special efforts also were continued this past year to increase liaison with the Michigan Youth Commission, Michigan Congress of Parents and Teachers, Michigan Press Association, Michigan Council of Churches, Michigan Adult Education Association, and many others.

TV News Films. As a new project this past year, MSMS provided to TV stations short films of MSMS officials being interviewed by the Executive Director on current issues of medical concern. The film clips (16 mm, sound) were produced at MSMS headquarters by a commercial motion picture firm and sent to 20 TV stations in Michigan. Follow-up questionnaires indicated the TV stations valued such cooperation and welcomed additional films. The subject matter was carefully chosen to be pertinent to MSMS concerns and the public interest. Topics include physician manpower, crime prevention, venereal disease control, and others. Assistance was given on specific subjects to television stations in Detroit, Grand Rapids, Cadillac, Flint, Kalamazoo, and other communities.

Television. The "Formula" television series presented by the Michigan Association of the Professions over WJIM-TV, Lansing, each Tuesday from 7:00-7:30 p.m., dealt with the health topics and featured MSMS members. Although produced by MAP, this series represented the major single effort put forth by MSMS to inform the public on health matters. MSMS Executive Director Brenneman acted as host for the third successive year.

Conference on Medical News Reporting. For the first time, this conference was held at the University of Michigan, with excellent cooperation from the Medical School. The event was shifted to Ann Arbor to help commemorate the U-M Sesquicentennial. About 50 newspaper editors and science writers, radio news editors, health organization public relations experts and university information service officials along with Michigan physicians interested in better communications participated in the day-long seminar.

Radio. Each week, MSMS reached thousands of Michigan residents through the cooperation of WUOM at Ann Arbor and some 40 Michigan radio stations. MSMS members taped both 5-minute health messages and 15-minute discussions about health medical matters at the WUOM studios in Ann Arbor. Radio stations continued to welcome and use these tapes as an important public service contribution.

Career Recruitment. MSMS and its component societies continued this past year to focus attention on the desire of physicians to recruit more workers in the many related health fields, and on the need for more physicians. Many career booklets have been distributed (particularly through the Health Careers Mobile), many speeches made at school assemblies, considerable help was provided to developing Explorer Medical Clubs, etc. Working hand-in-hand with the component medical societies in the many communities have been the Woman's Auxiliary units. Their aid has been of great value.

Conferences. In addition to the MSMS Conference on Medical News Reporting, MSMS-sponsored conferences provided good public relations values, as well as postgraduate educational service. (See Postgraduate Education for listing.) Largest attendance increase occurred at the Second Conference on the Medical Aspects of High School Sports, which drew 300 team physicians, coaches, etc., far more than the 60 who attended in 1966.

These conferences provided opportunities for news reporters from press, radio and television to cover the event and to interpret MSMS concerns to the public.

Legal and Governmental Affairs. The Council is pleased to report that MSMS' total governmental relations program has met with a number of significant successes since the 1966 meeting of the House of Delegates. The total program, which encompasses considerably more than the formal session of the State Legislature, demands an increasing amount of The Council's time and energies each succeeding year.

Government's relationships to the practice of medicine grow more complex each year. Legislatively, intensive activity is now pursued on a year-around basis. If the State Legislature is not meeting as a body, many of its committees are engaged in exhaustive study of health matters. Administratively, the several major agencies of government responsible for health programs require the establishment and maintenance of effective channels of communication with medicine. Concurrently, MSMS must maintain efficient liaison with a myriad of professional and health-related groups and organizations in the private sector, whose interests in governmental matters support, parallel, or oppose those of MSMS.

During this past year, these administrative aspects of government-in-medicine have required the time of a staff team, to make maximum data available to The Council, Legal Affairs Committee, Governmental Medical Care Programs Committee and other MSMS operating units. Intensified utilization of legal counsel has been required. Effort was constantly made not only to solve but to anticipate problems.

A balanced and effective legislative program was implemented by the Legal Affairs Committee and staff during 1967, as will be reported in detail in the Legal Affairs Committee's Annual Report. Good health bills were written, effective introducers were obtained and informed, testimony was prepared and delivered, and the MSMS membership was kept currently informed of progress through several publications. Not one proposed new law opposed by MSMS was enacted during the 1967 regular legislative session. Several new laws were enacted which MSMS itself drafted, sponsored or urged, dealing with PKU, physician immunity, physician licensing, blood transfusions, nursing, and public safety.

Throughout the state during early 1967 component society leadership received detailed reports on the Society's governmental activities during the "CPC" meeting series supplemented by the Informational Conference for MSMS Leaders conducted in Detroit in May. Specialized staff personnel familiar with the inter-related facets of governmental activities has enabled MSMS to better serve both its members and the public.

Invaluable assistance was received from a large segment of the total Society in the effort to provide legislators with information on health matters. Each year component medical societies are making a more successful effort to communicate with the lawmakers in their areas. Such activity is an indispensable adjunct to any legislative program.

Medical Economics

Second Revision of 1965 Michigan Relative Value Study. The Committee on Relative Value Study, after consulting with the Michigan Society of Internal Medicine, the Michigan Academy of General Practice and other specialty societies, completely revised the medical component of the 1965 Michigan RVS. A new more flexible approach to both Visits and Consultations has been employed so that a particular service can be appropriately identified within a broad range of unit values. The In-Patient section has been retained with some modification and several improvements were made in the Psychiatric, Cardiovascular, Pulmonary Evaluation, Allergy, Dermatological Procedures and remaining sections.

Hospital Utilization Review Manual. The 1966 House of Delegates did not approve the Hospital Utilization Review Manual.

Subsequently, however, The Council received several resolutions from component societies and specialty groups urging reconsideration of the Manual at a special session of the House.

The Council noted that the Bylaws provided mechanisms for the calling of a special session and decided to take no initiative in such a call. Rather, The Council believed that a committee should be assigned the task, of restudying the Manual and making recommendations for improvement.

Therefore, The Council, in December, referred the Hospital Utilization Review Manual back to the original committee for recommendations in light of the House of Delegates actions.

The Committee on Evaluation of Prepaid Medical Services held meetings to reconsider the "Hospital Utilization Review Manual" in light of the actions of the 1966 House of Delegates. The Chairman met separately with members of the reference committee that considered the Committee's 1965-66 Annual Report. Based on these discussions, the Committee revised the text of the Manual.

The revised Manual, opinions of MSMS Legal Counsel and available comments on cost implications have been sent to all officers, delegates and alternate delegates prior to the September meeting of the House of Delegates.

Medicine and Osteopathy. The Committee on Medicine and Osteopathy and the Legal Affairs Committee are consulting with MSMS Legal Counsel in the development of a bill to establish a single medical practice act in Michigan. The matter of a single medical practice act will be under study by the House State Affairs Committee. The Committee has under development a white paper which will contain a comprehensive positive program to resolve the MD-DO problem in Michigan.

The Chairman and members of the Committee have met with component medical societies to discuss both state and local problems regarding MD-DO relationships.

Courses on Medical Economics and Ethics. Lectures on medical economics and ethics were continued at the University of Michigan Medical School in Ann Arbor under the sponsorship of the Committee on Courses on Medical Economics and Ethics. The services of this committee have been offered to both Michigan State University College of Human Medicine and Wayne State University School of Medicine but, to date, no request for direct participation has been initiated by either school.

Liaison with State Bar of Michigan. The Liaison Committee with the State Bar of Michigan has the following matters under active study with the State Bar:

A. The difference between "legal" and "physical" definitions of disability as well as criteria upon which a disability determination is made.

B. The establishment of a medical advisory committee to the Workmen's Compensation Department.

C. Remuneration for a physician in the event his scheduled court appearance is cancelled.

These matters will be discussed in full at a joint meeting of this Committee and representatives of the Medical Legal Department of the State Bar at a meeting which has been scheduled for late fall.

Group Disability Insurance for Employees of MSMS Members. It is the consensus of the Committee on Professional Insurance Plans that, if doctors are to compete for skilled employees today, they must be in a position to offer benefit programs such as those available through industry.

To this end this Committee is developing a new program of disability income insurance for employees of physicians.

This program will contain a choice of benefits from $100 to $400 monthly with optional coverages from 1st day accident and 8th day sickness, up to 31st day accident or sickness.

It is anticipated that this new insurance program will be finalized and ready for presentation to The Council this fall.

RVS Conversion Factor. The House of Delegates Committee to Determine Monetary Value of Unit of Relative Value Scale is now studying changes in the cost of living and other economic data in preparation for its meeting in August. At this meeting a redetermination of the monetary conversion factor to the Michigan RVS will be made.

Medical Staff Surveys. The House of Delegates Committee on Medical Staff Survey of Hospitals has studied the survey techniques of the Joint Commission on Accreditation of Hospitals as well as the California Medical Association Medical Staff Survey Program. The Committee has developed guidelines to insure that it operates in an efficient and effective manner. These guidelines will be presented to the House of Delegates for approval in September.

Long-Range Planning. The Committee on Medical Socio-Economics position paper project is progressing nicely. This project comprises having experts, involved in shaping the environment that will surround the future practice of private medicine, submit position papers describing the future in their fields of knowledge.

Several papers have been received and negotiations for the remaining papers necessary to complete the project are being carried out.

Two of these thought-provoking papers, "The Future of Health Insurance Prepayment and Medicine — a View of 1985," by Charles P. Hall, Jr., Ph.D., and "The Outlook for Group Practice — Prepayment Direct Service Plans during the Next Twenty Years," by Caldwell B. Esselstyn, MD, have been published in *Michigan Medicine.* These papers are being reviewed by this Committee as well as by component society economic committees so that MSMS can develop constructive programs to meet the challenge of the future.

PART II

Annual Reports of Committees

Annual reports from the following committees have been reviewed by The Council:

Committees of The Council
International Health
Nursing
Hospital Relations
Workmen's Compensation
Liaison with State Executive Office
Medicine and Religion
Liaison with State Bar of Michigan
Courses on Medical Economics and Ethics
Evaluation of Prepaid Medical Services
Liaison with Residents, Interns, Medical Students
Beaumont Memorial
Liaison with Michigan Crippled Children Commission
Liaison with Michigan State Pharmaceutical Association
Liaison with State Board of Registration in Medicine
Medical Aspects of Organized Athletics
Michigan Medical History
Alcoholism & Drug Addiction
Committees of the Society
Medical Socio-Economics
Medicine and Osteopathy
Public Health
Rural Medical Service
Advisory to Michigan State Medical Assistants Society
Governmental Medical Care Programs
Postgraduate Medical Education
Blood Banks
Cardiac Disease Control
Maternal Health
Occupational Health
Highway Accident Prevention
Mental Health
Aging

The annual reports of the following committees will not be considered by The Council until its September 24 meeting. If there are any comments The Council wishes to make regarding these reports, they will be transmitted to the House in the verbal report of Council Chairman Mason.

Committees of The Council
Education Liaison
Relative Value Study
Disaster Medical Care
Eye Care
Rehabilitation
Committees of the Society
Public Relations
Professional Insurance Plans
Cancer
Child Welfare
Diabetes
Iodized Salt
Respiratory Diseases
Venereal Disease Control
Scientific Radio & Television
Advisory to Woman's Auxiliary
Legal Affairs

PART III

Matters Referred to the Council By the 1966 House of Delegates

Support of Four-Year Medical School at Michigan State University. Resolution 1 supported a request to the State Board of Education that MSU be granted authority to expand its pre-clinical College of Human Medicine to a full college granting the degree of doctor of medicine.

This resolution was sent to the State Board of Education along with letters urging approval of the MSU request by the Board. A letter and copy of the resolution also went to the Governor. Subsequently the Board did grant permission to MSU for this proposed expansion.

Support of Maximum Development of Wayne, U-M, and MSU Medical Schools. Resolution 2 urged that the Legislature, as well as the Governor and his staff, be urged to provide sufficient funds for maximum development of medical education facilities at the three universities.

Copies of the resolution went to the State Board of Education, Michigan State University, the Chairman of the Citizens Committee on Education for Health Care, Governor Romney, and members of the House and Senate education and appropriations committees.

Concept of 'Usual and Customary Fees." Resolution 29 directed that The Council communicate the concept "that physicians' and surgeons' 'usual and customary fees' be recognized as flexible in nature and variable from time to time" to the appropriate governmental units.

This has been implemented on a continuing basis by the Committee on Governmental Medical Care Programs.

Committee re Medical School Expansion. Resolution 31 called for the appointment of a committee including legislators, medical educators and doctors of medicine "to provide continuing pressure for medical school expansion."

MD representatives of the committee have been selected and invited to serve.

Acceptance of National Board of Medical Examiners Certifications for Michigan Licensure. Resolution 60 called for suitable legislation to be drafted to enable the State Board of Registration to accept these certificates as well as the present Michigan examination.

Such legislation was drafted, submitted to the Legal Affairs Committee, and introduced in the Legislature. The Legislature subsequently adopted the bill.

Repeal of Basic Science Law. Resolution 62 called for suitable legislation to be drafted and introduced into the Legislature, to repeal the Michigan Basic Science Law.

Such legislation was drafted, submitted to the Legal Affairs Committee, and introduced in the Legislature. However, the Bill was returned to committee in the House for further study, after passing the Senate. It may be acted upon by the 1968 Legislature.

Workshops for MSMS Delegates. Resolution 76 called for The Council to conduct a Delegates' Workshop on the day of, but prior to, the opening of the Annual Session of the House of Delegates, for the "exchange of viewpoints on mutual problems."

A planning committee composed of the MSMS President, Speaker and Council Chairman was appointed to develop, with the assistance of the staff, an agenda and format for the workshop.

Separate Billing to Patients by Hospital-Based Physicians. In discussing a committee report which reviewed implementation of 1966 House Resolution 52, The Council adopted a motion specifically pointing out that the House of Delegates discussion on this resolution referred to anesthesiologists, pathologists, radiologists, and physiatrists as hospital-based physicians, and did not include physicians in training.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, made the folowing comments on Part I and Part III of The Council's Report:

Part I — Council Activities:

A — Your Reference Committee commends The Council for its work in general to provide guidelines to Federal health programs, and in particular to the major liaison role contributed by the Committee on Governmental Medical Care Programs.

B — Guidelines for Health Screening Tests:

Your Reference Committee feels these Guidelines will do much to indicate the willingness of the medical societies to provide leadership and reference for hitherto meaningless results from multiple programs of questionable purpose.

C — Definition of a Specialist:

Recommendations and reaffirmation by The Council of the Definition of a Specialist was approved by your Reference Comimittee, although some doubt was expressed as to such need in lieu of new Blue Shield contracts paying the physicians their usual, customary and prevailing fees.

D — The Reference Committee's attention was called to The Council's institution of a new, modern, efficient bookkeeping system operating under the direction of a reputable CPA firm. Through this system greater ease has been noted in the management of the Society's operational financial mobility.

E — Multiple functions of The Council on improved communication between Society echelons, postgraduate education and public relations, were reviewed and accepted for information without further comment.

Part III — Matters Referred by the 1966 House:

The Reference Committee reviewed this portion of the Report in detail and recommended it be received for information.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE REPORTS

15. Annual Reports of Council Committees

COMMITTEE ON ALCOHOLISM AND DRUG ADDICTION

C. K. Stroup, MD, *Chairman*

During the past year, the Committee met three times. In addition, its Subcommittee on Alcoholism Education Program met to formulate a program of the MSMS to concentrate efforts and publicity concerned with alcoholism during the months of December, 1966, and January, 1967.

The Committee has continued its liaison with the Michigan Department of Public Health and with the Michigan Department of Mental Health.

The Committee reviewed all legislation concerned with alcoholism, drunken driving, and drug addiction and its recommended actions were forwarded to The Council.

The Committee reviewed the American Medical Association and the National Academy of Sciences - National Research Council established guidelines relative to the appropriate and ethical use of narcotics and the treatment of drug dependent persons. The guidelines are utilized by the Federal Bureau of Narcotics in establishing relevant Bureau policies. The adoption of the revised guidelines has been recommended by the Committee and is under study at the present time by The Council.

The Committee has also recommended to The Council that it be empowered to serve as a consultative group to the members of the MSMS on any problems that physicians might have in the area of drug dependency.

The Committee has referred to the MSMS Liaison Committee with the Michigan State Board of Registration in Medicine its recommendation that the Michigan State Board of Registration in Medicine be expanded to include a group of physicians, qualified in drug dependency, to serve in an advisory capacity to law enforcement agencies and any kind of problem having to do with misuse and improper dispensing of drugs by physicians.

The Committee is studying a possible statement regarding the educational aspects, the treatment of care and rehabilitation of drug dependent persons.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, considered the work of this committee to be urgent and vital, recommending the report be received as an interim report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AWARDS

H. J. Meier, MD, *Chairman*

During 1966-67, MSMS continued its award program to recognize MSMS members for service to the profession and the public.

Awards to National Presidents.

As in the past, MSMS will present its National Presidents Award to MSMS members who are serving as presidents of national medical organizations. This year, the Committee presented its report to The Council in July but recommended that the award presentation be at the Annual Dinner Dance. (MSMS has not presented these awards since April, 1966, because the former spring "County Secretaries - Public Relations Seminar" was not held this past spring.)

The following are being honored:

George H. Agate, MD, Lansing
—Conference of State and Territorial Epidemiologists

Luther C. Carpenter, MD, Grand Rapids
—Commission on Professional and Hospital Activities

A. James French, MD, Ann Arbor
—International Academy of Pathology

William N. Hubbard, Jr., MD, Ann Arbor
—Association of American Medical Colleges

Clarence S. Livingood, MD, Detroit
—American Academy of Dermatology

Norman D. Nigro, MD, Detroit
—American Proctologic Society

Lionel F. Swan, MD, Detroit
—National Medical Association

Ross V. Taylor, MD, Jackson
—American Therapeutic Society

Raymond W. Waggoner, MD, Ann Arbor
—American College of Psychiatrists and
—American Association of Professors of Psychology

50-Year Awards:

The 1967 House of Delegates will recognize physicians who have served the science of medicine for 50 years or more. They are:

Dickinson-Iron
William J. Kofmehl, MD, Stambaugh

Genesee
J. Leonidas Leach, MD, Flint
R. G. Brain, MD, Flint

Gratiot-Isabella-Clare
  Myron G. Becker, MD, Edmore

Ingham
  William C. Behen, MD, Lansing
  Charles A. Behney, MD, Bisbee, Arizona
  Maurice C. Loree, MD, Lansing
  Arthur W. Newitt, MD, Lansing
  T. P. VanderZalm, MD, Lansing

Jackson
  Miar J. McLaughlin, MD, Jackson

Kent
  William J. Butler, MD, Tucson, Arizona
  Harry Lieffers, MD, Grand Rapids

Macomb
  William Kane, MD, Mt. Clemens
  Arthur Erkfitz, MD, St. Clair Shores

Oakland
  Ira M. Altshuler, MD, Southfield

Ottawa
  William C. Kools, MD, Holland

St. Clair
  G. Douglas Treadgold, MD, Port Huron

Shiawassee
  Alfred L. Arnold, Jr., MD, Ovid

Washtenaw
  Algernon A. Palmer, MD, Chelsea

Wayne
  Domenico M. Annessa, MD, Detroit
  Lloyd K. Babcock, MD, Detroit
  Isadore I. Bittker, MD, Oak Park
  William L. Brosius, MD, Rochester
  Robin Buerki, MD, Detroit
  John M. Carter, MD, Ft. Lauderdale, Florida
  Leon B. Cowen, MD, Detroit
  Robert L. Cowen, MD, Detroit
  Howard P. Doub, MD, Detroit
  James W. Hawkins, MD, Sarasota, Florida
  William E. Henderson, MD, Harper Woods
  Herbert I. Kallet, MD, Detroit
  Edward D. King, MD, Grosse Pointe
  Joseph S. Leszynski, MD, Detroit
  John W. MacKenzie, MD, Grosse Pointe
  William T. McAlonan, MD, Detroit
  Vasil P. Moisides, MD, Detroit
  C. W. Sellers, MD, Detroit
  Elmer C. Texter, MD, Detroit
  Roy D. Tupper, MD, Detroit
  Clarence E. Weaver, MD, Deerfield Beach, Florida

Special Award:

A special award was authorized by the MSMS Council in July, in appreciation to Oliver B. McGillicuddy, MD, Lansing, who resigned as MSMS Secretary. Doctor McGillicuddy, a former Chairman of The Council and MSMS President in 1964-65, served one year as Secretary, resigning this summer.

Members of the Committee include: L. R. Leader, MD; J. J. Lightbody, MD; and C. Allen Payne, MD.

THE HOUSE, based on the recommendations of the Awards Committee, did present the awards outlined in this report (see Section on Presentations and Awards).

COMMITTEE ON BEAUMONT MEMORIAL

Robert J. Mason, MD, *Chairman*

All of the Beaumont memorabilia and historical effects are in good condition and carefully displayed in the Beaumont Memorial on Mackinac Island.

The Committee is ready to advise and deal with problems related to the Memorial or to the acquisition of further historical items.

All Committee business was handled by mail and telephone this year. Consequently there was no need for a formal meeting.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended this report be received for information.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON COURSES ON MEDICAL ECONOMICS AND ETHICS

R. O. Kraft, MD, *Chairman*

The courses on medical economics and ethics were continued during 1966-67 at the University of Michigan Medical School in Ann Arbor. During the fall of 1966 the meetings were held weekly during noon hours. During the winter and spring of 1967 the meetings were changed to the evening at monthly intervals. The change in scheduling for the courses was approved by Dean Hubbard and attendance improved considerably.

A list of the varied subject material covered during the courses follows:

Richard O. Kraft, MD, "Explanation of the Course."

Richard O. Kraft, MD, "Establishing a Fee Schedule."

Captain Max Strother, Selective Service Office, "A Discussion of the Physician's Draft - Past, Present & Future."

Timothy Hogan and Douglas Willson, Professional Management, "Solo versus Group Practice - Advantages and Disadvantages."

James R. Breakey, Jr., Circuit Judge, "The Physician and the Law."

C. Howard Ross, MD, "A History of Medical Ethics."

Norman Davis, Sears, Roebuck Foundation, Chicago, "Opportunities for General Practice in Small Communities as Assisted by the Sears-Roebuck Foundation."

Harry Zemmer, MD, Lapeer, Michigan, "What It Means to be a Medical Missionary."

Mr. Robert Kehoe, Social Security Administration, "Social Security and the Physician."

C. Gardner Child, MD, University of Michigan, "Trends in Medical Education."

Lt. Robert L. Decker, U. S. Navy, "Opportunities for Physicians in the Military Services."

Charles Canty, MD, "Experiences of a Physician with Our Armed Forces in Southeast Asia."

Jospeh Noya, MD, Department of Health, Education and Welfare, "Career Opportunities in the Public Health Service."

Professor Donald MacDonald, School of Business Administration, University of Michigan, "What the Physician Should Know About Insurance."

Professor Donald MacDonald, University of Michigan, "What the Physician Should Know About Insurance" (second part).

Richard O. Kraft, MD, "Morality and Major Specialty Procedures in the Aged and Infirm."

Michael Papo, MD, "General Practice 1966."

John Gosling, MD, Women's Hospital, University Medical Center, "Future and Practice of Obstetrics and Gynecology."

William Olsen, MD, Department of Surgery, University of Michigan, "Academic versus Private Practice."

Mr. John Doherty, Michigan Health Council, "Placement Opportunities in Michigan at this Time."

Michigan State University College of Human Medicine and Wayne State University School of Medicine were both contacted in hopes that the Michigan State Medical Society Committee on Courses on Medical Economics and Ethics could participate more fully in appropriate areas in their curricula. This correspondence was warmly received, but to date no request for direct participation has been initiated by either school. This material apparently is covered adequately at Wayne State and Michigan State Universities under their present curricula.

The activities of this Committee will continue through the ensuing years.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, acknowledged with pride the excellent schedule of lectures presented and reiterated the recommendation that these subjects be recorded and edited for future use.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON DISASTER MEDICAL CARE

C. P. Anderson, MD, *Chairman*

The Committee on Disaster Medical Care devoted its attention to study of training of physicians and ancillary personnel in disaster care. Excellent reports were presented to the Committee by Alexander J. Walt, MD, Assistant Dean and Chairman of the Department of Surgery at Wayne University, and Charles F. Frey, MD, Assistant Professor of Surgery at University of Michigan, regarding the training of undergraduates and graduates in trauma and emergency care as well as the implementation of the MEND program in their respective schools. These reports were presented both in written form and in person. From these discussions it appears the present graduates from these two schools are exceptionally well trained in disaster and emergency care.

Although many of the postgraduate sessions of the University of Michigan have items on care of trauma it appears that much more could be offered on emergency and disaster care if component societies and local hospitals indicated an interest in seeing this phase of postgraduate education expanded. Considerable information on staffing of emergency rooms of hospitals and the various methods of providing adequate care was discussed without recognition of any single solution as outstanding. A possibility seems to be the development of specialists in emergency care who would devote their entire time to this aspect of medical care (especially in urban areas) and who would supervise a corps of technicians with specialized skills.

Action of other MSMS committees regarding emergency services by ambulance and police was discussed. A new state law is being considered in this regard and it was recommended that the Society be represented at the hearings. All members of the Committee and its advisors expressed concern over the wide variations in quality of service available to sick or injured. The Michigan Department of Public Health has recently completed a survey of ambulance services which will be made available to the Committee in the immediate future. The availability of a course at the University of Michigan for police and ambulance personnel was noted as was a planned training course of the Michigan Department of Public Health.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, stated:

"The report of this Committee was received and is recommended for information. In line with national surveys, the need for emergency first-aid education is paramount not only to the general population but to medical and ancillary medical personnel alike. Too few physicians are well indoctrinated in emergency first aid.

"The importance of adequate medical supervision at the scene of highway or mass industrial accidents shares equal or greater importance with wartime disasters. Education beginning in elementary school, with repetition at high school and college level for all students, should be encouraged.

"Medical students should be well indoctrinated in emergency-room techniques, drugs and dosages. Ambulance services should be upgraded in certification for licensure and reimbursed accordingly, requiring adequate knowledge of conduct at disaster scenes.

"Your Reference Committee recommends that this Committee's activities be continued to achieve this end."

THE HOUSE adopted the report of the Reference Committee.

EDUCATION LIAISON COMMITTEE

Don Marshall, MD, *Chairman*

The Education Liaison Committee and its two active subcommittees have studied many matters in the broad area of "medical profession - medical school relationships" and have considered many specific matters referred from The Council.

The parent committee has directed the work of a Subcommittee on Paramedical Education, which is in its second year of work as an outgrowth of Resolution 20 of the 1965 House of Delegates, and the Subcommittee on General Practice Education, which has completed its first year of work on Resolution 50, also adopted by the 1965 House of Delegates.

The deans of the three Michigan medical schools and their representatives have consistently cooperated fully with the parent committee and its two subcommittees. The Chairman is grateful for the excellent advice and support from the medical educators. The educators have expressed their opinions that the work of the Education Liaison Committee as "vital and important in maintaining and improving liaison between the Medical Society and the medical schools."

The important reports of the two subcommittees will follow some general comments about the work of the Education Liaison Committee in other fields of concern:

Reports from the Medical Schools: Regularly at the Committee meetings, representatives of the three medical schools gave brief progress reports on enrollments, curriculum studies, financial needs, etc. Excellent cooperation continues to be given by the medical schools to this Committee and thus to The Council and Society. (Representatives of the medical schools also are usually in attendance at the MSMS Council meetings.)

MARMP: The Education Liaison Committee at each meeting heard a brief report and discussed the progress of the Michigan Association for Regional Medical Programs (MARMP). Because the project involves the three medical schools, MSMS and many other groups, this Committee will continue to keep abreast of the Michigan plans. Representatives of the MSMS Committees on Cancer, Cardiac Disease Control, Postgraduate Medical Education, Diabetes and Rehabilitation were invited to the March meeting and efforts were made throughout the year to maintain good communications. (The Chairman of the Education Liaison Committee serves as the official MSMS representative to MARMP, and a member of the Committee (D. Bonta Hiscoe, MD) is the alternate representative.) MARMP received a grant on June 2 of $1,285,155 from the U. S. Public Health Service's National Institutes of Health; of the grant $161,781 was for a central MARMP staff. Albert E. Heustis, MD, Director of the Michigan Department of Public Health for 19 years, has been appointed as Executive Director of MARMP. He will begin these new duties October 1.

Evaluation of National Reports: Committee members reviewed the following reports in considerable detail: Citizens Commission on Graduate Medical Education (Millis Report); AMA Ad Hoc Committee on Education for Family Practice (Willard Report); Committee on the Association of American Medical Colleges (Coggeshall Report); National Commission on Community Health (Folsom Report). The Committee also has watched the development of the new National Advisory Commission on Health Manpower established in 1966 by the President. The Committee also studied some of the speeches given at the 1966 AMA Conference on Medical Education, and some of the special digests prepared by the Chairman, who attended.

The Education Liaison Committee has sent to The MSMS Council a recommendation on the Millis Report.

The AMA House of Delegates in November, 1966 invited state and county medical societies to study the report and submit their reactions. The AMA House in Atlantic City in June 1967 approved a reference committee report that urged all interested members and county and state groups to submit comments, suggestions or recommendations to the AMA Council on Medical Education and also to the AMA Council on Medical Services.

The recommendation to The MSMS Council was adopted by the Education Liaison Committee as forwarded from the Subcommittee on General Practice Education. The Committee recommendation to The Council agreed generally with the Millis Report recommendations but took no position on the last recommendation about the exact composition of the proposed Commission on Graduate Medical Education. (Several county medical societies in Michigan already have relayed their comments to the AMA.)

(Consideration by The Council of the recommendation on the Millis Report is on the agenda for the MSMS Council meeting September 24.)

Internships: The Committee began a study of possible changing patterns of selection of internships by graduating medical school students. Much research must be done before conclusions can be drawn and proposals considered. The AMA upon a Michigan request, has agreed to conduct a research study too into the subject. Generally, MSMS is eager and willing to cooperate with hospitals, medical schools, county medical societies and all others to obtain more interns for Michigan hospitals.

The Council authorized the appointment of a subcommittee task force to explore the internship question—and also hand-in-hand to consider how to attract interns to residency positions in Michigan, and the factors that lead physicians to settle in Michigan for their permanent careers.

Some preliminary fact-finding work has been done for the first meeting this fall of the task-force group.

Resolution 51 of the 1966 MSMS House of Delegates: The Council requested the Education Liaison Committee to explore the intent of Resolution 51, which sought to encourage the enactment of legislation to promote the extern concept of clinical training and provide necessary legal protection. The Committee conferred with the MSMS Legal Counsel and learned that the hospital medical education directors also are checking on this matter. The Education Liaison Committee has recommended that the MSMS Council refer the matter to the Legal Affairs Committee for further study and implementation in its contemplated revision of the Michigan Medical Practice Act.

Encouragement to Michigan Junior Colleges: Several times during the year, community-junior colleges wrote to the Committee about plans to inaugurate new programs in the training of health workers. The Committee encouraged their efforts provided they use the guidelines developed by the American Medical Association in order to assure proper standards of training.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended acceptance of the report noting the admirable volume of work in the past year.

THE HOUSE adopted the report of the Reference Committee.

SUBCOMMITTEE ON GENERAL PRACTICE EDUCATION

J. B. Rowe, MD, *Chairman*

Adoption by the 1965 MSMS House of Delegates of Resolution 50 led to the creation and the work of this Subcommittee. Resolution 50, introduced by Fred C. Brace, MD, Grand Rapids, a past president of the Michigan Academy of General Practice, did three things: 1) Asked The Council to appoint a special committee including medical school representatives; 2) Said the committee should have the purpose of evaluating and setting up a preceptorship in family practice; 3) Asked that the committee also consider other methods for stimulating, interesting and training more young physicians in general and rural practice in Michigan.

During 1965-66 . . .

The Council referred the resolution to the Education Liaison Committee for a good, first look at the issues involved.

The Education Liaison Committee obtained considerable information about preceptorships from other states and reported to the 1966 House of Delegates that "The preceptorship approach is only one part of a possible total program."

The Education Liaison Committee in August, 1966, recommended to The Council that it appoint a subcommittee of one or more representatives of (1) the Education Liaison Committee, (2) the three medical schools, and (3) the MSMS Section on General Practice, "to consider the problems of general and rural practice and its relations to the medical school curricula."

The progress report was accepted by the 1966 House of Delegates.

The Council in early 1966-67 appointed a Subcommittee on General Practice Education, with representatives as specified by the Resolution.

The Subcommittee has met several times to confer with representatives of the medical schools and to study materials from the AMA and other sources. The Subcommittee invited the Chairman of the MSMS Committee on Rural Medical Service to attend all meetings as a guest.

The Subcommittee studied some of the many ramifications of getting more physicians for general and rural practice and finds the solutions to be very complex.

Representatives of the three medical schools presented oral and/or written reports about their tentative plans to train more physicians for general and rural practice. The Committee was pleased and impressed with the changes being considered and implemented by the schools.

Representatives of the three medical schools all reported that faculty members were deeply involved in curriculum study. The curriculum study groups also are studying the general practice recommendations in several recent national studies. These reports include the National Commission on Community Health Services (the Folsom Report); the Citizens Commission on Graduate Medical Education (the Millis Report); and the AMA Ad Hoc Committee on Education for Family Practice (the Willard Report).

The Subcommittee studied in detail the Report of the Citizens Commission on Graduate Medical Education. The reactions of the Subcommittee on the many recommendations in the Report were given to the Education Liaison Committee. (See item #3 in the Education Liaison Committee Annual Report for details.)

The Subcommittee was questioned in detail at almost every meeting by the medical school representatives who asked "What subject matter is unique to general practice and should be included in the medical school curriculum to help train students to be good physicians to provide comprehensive family care." Committee members offered some help and admitted the question was not an easy one.

The Subcommittee offers the following four recommendations regarding the Resolution 50 assignment to the Education Liaison Committee.

Recommendation 1: That the Subcommittee be discontinued at the end of 1966-67.

Recommendation 2: That the overall concern about more general practitioners become one of the on-going concerns of the Education Liaison Committee.

Recommendation 3: That the Chairman of The Council appoint the President-elect of the Michigan Academy of General Practice to a one-year term on the Education Liaison Committee.

Recommendation 4: That the following suggested medical society activities to encourage general practice in Michigan be referred to the General Practice Section of MSMS and to the Michigan Academy of General Practice for possible implementation.

a) That GP's throughout the state be invited to host one of the sophomore or junior medical students from the Michigan Medical schools for an on-the-scene experience some specific weekend.

b) That county medical societies maintain good relations with their local medical students and encourage them to practice in their hometowns or nearby small towns.

c) That MSMS encourage the idea that two young GP's go into the same smaller town at the same time and thus help assure some free time for each other.

The members of the Subcommittee have been conscientious in their study of this complex subject of general practice education.

The subject is one of great national importance and concern and is under study by the American Medical Association, the American Academy of General Practice, the medical schools of the nation, etc.

MSMS should continue to have a committee, such as the Education Liaison Committee, with the assigned responsibilities (1) to explore ways to further improve the education of general practice physicians in Michigan, and (2) to seek out new ways to increase the number of general practice family physicians in Michigan, especially in the rural and suburban areas.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recognized a conscientious effort has been made in studying the complex subject of general practice education. No solution has been concluded.

The problem of insufficient numbers of family physicians is real; the need for rural physicians is real; the improvement in the education of family physicians is not as much a problem as the improvement in his image and prestige among medical educators so that young aspirants will be encouraged to enter this field.

Your Reference Committee believes that MSMS should continue its efforts in exploring means of achieving this goal.

THE HOUSE adopted the report of the Reference Committee.

SUBCOMMITTEE ON PARAMEDICAL EDUCATION

H. J. Meier, MD, *Chairman*

The Paramedical Education Subcommittee, which held its first meeting April 13, 1966, to implement Resolution 20 of the 1965 House of Delegates, continued its study throughout 1966-67. (Resolution 20 of 1965 requested MSMS to explore the possibilities of training and using "physician assistants.")

The Subcommittee has followed an outline developed by the Chairman. Phase One has been a feasibility study; Phase Two, an attempt to develop the role of such an assistant; Phase Three, the consideration of the training program that would be required; and Phase Four, the ramifications of registrations, etc.

This past year, the Subcommittee has moved well into the feasibility study and on into the second and third phases. All three are closely inter-related and all three are complex.

The Subcommittee held special hearings about feasibility, role, and education with leaders and representatives of the Michigan Society of Internal Medicine and the Michigan Chapter of the American Academy of Pediatrics.

As the Subcommittee continued its study, it was generally agreed that a physician assistant (depending upon training) could be used by some Michigan physicians for some of the many duties in the office and in the hospital.

During the discussions it was pointed out that the student interested in becoming a physician assistant could be a young man or woman, but could also be an older person — such as a mother whose children were grown.

There has been discussion at every Subcommittee meeting and at every meeting of the parent committee about the extent and nature of the education and training for the physician assistant. The Subcommittee discussed these aspects with two representatives of the State Department of Public Education and with the Educational Director of the W. K. Kellogg Foundation, who has had considerable experience in New York State with paramedical education. The Kellogg Foundation official reported that the MSMS study about the physician assistant possibilities seems to be the only one involving a state medical society. He expressed the personal opinion that the U.S. Public Health Service would be willing to fund a pilot program to train physician assistants if done right.

The Subcommittee agreed that one of the first goals must be the development of a job description along with answers to some closely related questions. The educators pointed out that after the medical profession writes down such basic information, colleges and universities then would help decide what courses would be needed. Identified as key questions were these:

1. What kind of motor skills must the person have to serve as a physician assistant?
2. What kind of decisions will the person need to make?
3. What kinds of responsibilities will be given by the physician to the physician assistant?
4. How much and what kind of supervision will be given to the physician assistant?
5. What job relationships would the person have with nurses and the other health personnel?
6. What are the legal and insurance ramifications?
7. Where will the person work?

The Subcommittee decided that it should carry the first three phases of its study to interested MSMS members at the 1967 Annual Session. The Subcommittee and the Annual Session Program Committee have scheduled two periods at the 1967 Annual Session to talk with interested members.

After the Annual Session, the Subcommittee hopes to be better able to develop a job description and to work with educators and medical school representatives to draw up a curriculum.

The Council has authorized the Education Liaison Committee and the Subcommittee to request whatever grants might be necessary for research and planning. The U.S. Department of Health, Education and Welfare's Bureau of Health Manpower has grants available to develop, demonstrate and evaluate curricula for physician assistants.

The Committee has set March 1, 1968, as the deadline for completion of the job description and grant request.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, studied the interim progress report which appeared to be well along a course described in four phases. The Committee reserved further comment until the final report in 1968.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EVALUATION OF PREPAID MEDICAL SERVICES

B. C. Payne, MD, *Chairman*

This Committee, at the request of The Council, has held meetings to reconsider the "Hospital Utilization Review Manual" in light of the actions of the 1966 House of Delegates. The Chairman has met separately with members of the Reference Committee that considered this Committee's last year (1965-66) Annual Report so we could collect and consider the expressions of opposition to the Manual as published. We have also reviewed the debate of the House of Delegates on this matter.

Based upon these discussions, the Committee has revised the text of the "Hospital Utilization Review Manual" and it has been approved by the majority members of the Committee.

The Committee has received and reviewed the requests of four county medical societies requesting reconsideration by the House of Delegates of its actions regarding the 1965-66 report of this Committee and the "Hospital Utilization Review Manual." Several other reactions in favor of the Manual have been forwarded to the Committee from individual hospitals and the Michigan Society of Internal Medicine.

At the direction of the House of Delegates the Committee also re-investigated the possibility of obtaining sufficient information regarding length of stay and use of laboratory and radiologic services by Michigan Medical Service - Michigan Hospital Service subscribers. The data supplied by Michigan Medical Service was identical to that supplied in January, 1966. A request from this Committee as well as from The Council has confirmed the fact that all data compiled by Michigan Medical Service is in diagnostic groupings that do not lend themselves to critical analysis as to frequency or appropriateness of use by individual diagnosis. This was confirmed in a letter to The Council from Mr. John McCabe, President of M.M.S.

As an example there are a total of 99 diagnostic groupings on which data are collected. Only 14 of these are more or less explicit diagnostic categories and include:

Syphilis and its reguelae
Malaria
Diabetes Mellitus
Rheumatic Fever
Chronic Rheumatic Heart Disease
Arteriosclerotic and degenerative heart disease
Hypertensive disease
Acute upper respiratory infections
Influenza
Pneumonia
Bronchitis
Appendicitis
Abortion
Delivery without complication
The remainder are grouped in classes as follows:
Malignant neoplasm of digestive organs and peritoneum
Allergic Disorders
Diseases of blood and blood forming organs
Vascular lesions affecting central nervous system
Diseases of the stomach and duodenum
Diseases of the liver, gall bladder and pancreas
Diseases of the breast, ovary, fallopian tube and parametrium
Fractures of the lower limb

These are representative samples and demonstrated to the Committee the impossibility of making meaningful statements regarding use in any but the 14 specific disease entities.

Even with meaningful statistics the Committee concluded that a satisfactory evaluation required the initial development of a tool for measurement for evaluation. This led to the acceptance of the methodology described in the 1962 "Study of Hospital and Medical Economics" with the refinements presently contained in the "Hospital Utilization Review Manual."

In response to the above consultations the Committee makes the following observations: The 1962 study done in great depth and at great expense reported the experience in Michigan of days of hospital stay by diagnosis, days of overstay and understay and appropriateness of admission. Also reported were frequency of laboratory and radiologic procedures related to diagnosis, source of payment and characteristics of the physician attending the case. It related use patterns to size of hospital, degree of specialization within the hospital and the level of teaching responsibility of the hospital.

The Committee therefore observed that the job of identification of the problem had been accomplished. It further observed that the methodology developed in the "Study of Hospital and Medical Economics" should be employed by hospital medical staffs for the purpose of continued review of medical care in relation to quality of services rendered and effectiveness of hospital use. This recommendation was approved by the 1965 House of Delegates and to this end the "Hospital Utilization Review Manual" was prepared.

The House of Delegates of 1966 acted to cease publication and distribution of this Manual. This has been done, and to our knowledge, no copies of the Review Manual have been returned to MSMS.

The Council at its meeting of June 14 approved the following revised recommendations of this Committee:

(1) That the revised text of the "Hospital Utilization Review Manual" be made available to all officers, delegates and alternate delegates as quickly as possible and labeled "confidential" pending House of Delegates approval so that study, discussion and reaction takes place before the district councilor conferences in August.

(2) The MSMS Legal Counsel and possibly the Medical Protective Company of Fort Wayne, Indiana, be requested to give a formal opinion regarding the malpractice hazards posed by the revised "Hospital Utilization Review Manual." Material sent must be labeled "confidential."

(3) The Committee recommends that Michigan Medical Service and Michigan Hospital Service be requested to give an opinion regarding implications of the utilizaton of laboratory and radiologic services contained in the revised "Hospital Utilization Review Manual," with the understanding that their opinions also be made available to officers, delegates, and alternates prior to the September House of Delegates meeting. Material must be labeled "confidential."

(4) The Committee recommends that the 1967 House of Delegates review the revised "Hospital Utilization Review Manual" with the opinions of MSMS Legal Counsel and the available comments on cost implication.

(5) The Committee recommends that, if the House of Delegates approves the Revised Manual, it be distributed to physicians and hospitals at their request with an appropriate charge to cover costs of printing and mailing.

COMMITTEE ON EVALUATION OF PREPAID MEDICAL CARE MINORITY REPORT

A minority of the Committee does not concur in the report submitted to The Council of the Michigan State Medical Society. Our primary point of divergence is that the report and the findings of the Committee do not focus on the charge given this Committee as contained in the original Resolution 22 of the 1964 House of Delegates and as reaffirmed in 1966. The Committee in 1965 and 1966 found that it could not accomplish its charge with the resources available and offered a substitute which was rejected by the 1966 House of Delegates. The majority report reviews its past actions, confirms them, and resubmits them to The Council for transmittal to the 1967 House of Delegates. In effect, the Committee is saying its judgment is better than that of the House of Delegates.

A major fallacy in the functioning of the Committee has been an attempt to equate "Quality of Care" and "Utilization." It is true that there are many mutual ingredients, but they are far from synonymous. It is quite easy to envision situations presenting effective quality but poor utilization. The reverse may also occur. Our goal in the practice of medicine is to achieve quality with effective utilization of facilities in the best interests of the patient and of the community.

It has been claimed, and with some reason, that no matter how we attempt to camouflage or label the criteria developed as guides they will be considered as musts and form the base of practice. It has been claimed that the implementation of the proposed criteria would produce a significant increase in cost of providing medical care with some reservation as to whether it would produce a commensurate return in improved health. The majority feels that the effect on cost cannot be considered when deciding what a patient needs, and is not a primary concern of ours.

The minority finds that we physicians are held responsible for rising costs of health care. It is true that we have little to say and less authority for controlling this, but the fact remains that in the minds of the public it is the physician who is responsible. We must therefore attempt to assure ourselves that we are not producing an unjustifiable rise in the cost of medical care as a result of our recommendations.

We find that the Committee as a whole failed to devote adequate thought to alternative approaches to fulfilling our charge, and less effort to ascertaining the effect of the recommendations. We believe that there are other approaches that need to be explored more fully in meeting our obligation.

This should not be construed, however, as a rebuttal of the value of the concepts developed by Doctor Payne for the evaluation of the quality of medical care. The mechanism has a great potential for good. We believe it needs some further refinement, especially involvement of general practitioners for review. The current panels responsible for developing the criteria were too heavily weighted with medical school faculty and specialists (many of whom also have faculty appointments at one level or another). This has resulted in the development of criteria very nearly approaching the ideal in our present state of knowledge as taught to medical students and represents inclusion of more than is necessary to assure adequate diagnosis and care. We recognize that this is intended to serve only as a guide to utilization committees and that they must be modified to reflect the standard of care in the community in which they are being used. The reality is that in today's medico-legal environment with the discarding in some jurisdiction of the doctrine of the level of practice in that community and substituting the level of practice in a larger area, a guide such as this bearing the imprint of the Michigan State Medical Society or any of its committees becomes the standard for Michigan rather than a guide.

The minority is critical of the work of the Committee as reflected in the attendance at meetings. We have nothing but praise for the constancy and dedication of our Chairman, but participation by the Committee as a whole is open to criticism. We suggest to The Council that this record be reviewed.

The minority makes the following recommendations:

1. That The Council report to the House of Delegates that the 1966-67 Committee had not pursued its charge, but had reaffirmed its finding that a uniform mechanism of evaluating quality was more useful than a study of utilization.

2. That The Council recommend to the House of Delegates that the life of the Committee be extended.

3. That the Committee be reorganized with the appointment of a new Chairman and replacement of present members of the Committee in an attempt to find a new approach, including:

   a) Review of material actually available from Michigan Medical Service and Michigan Hospital Service.

   b) Review the possibility of correlating data available from the major carriers with that available through PAS.

   c) Exploration of the possibility of voluntary cooperation by selected hospitals and their staffs in the work of the Committee on Evaluation.

4. That the charge to the Committee be enlarged to include evaluation of the economic impact of its recommendations and the potential for improved care of the patient.

5. That the general publication of the Manual be deferred for at least one year. Individual copies could, however, be made available to members of the Society.

Respectfully submitted for the minority.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, after extensive hearings and deliberation made the following recommendations:

1. That the manual as it exists be not approved as a document of the Michigan State Medical Society.

2. Your Reference Committee, in recognition of some of the outstanding qualities of the manual, recommends that the Committee on Evaluation of Prepaid Medical Services be asked to explore usage of the manual by medical staffs of hospitals as a means of further studying the effectiveness of these guidelines.

3. That continued studies be encouraged by this House of Delegates in seeking answers which will insure continued improvements in the delivery of medical services.

4. That no action be taken on the Minority Report.

THE HOUSE approved Recommendations 1 and 2, amending Recommendation 3 to read, "That continued studies be encouraged by this House of Delegates in seeking answers which will insure continued improvements in the delivery of medical services, and that the President appoint a committee to implement Resolution 22, 1964, by January 1, 1968.

COMMITTEE ON EYE CARE

Robert T. Blackhurst, MD, *Chairman*

The Committee met with Doctor Edward A. Fitting of Services for the Blind, Department of Social Services, State of Michigan, and recommended that his Department participate in the program called "The Model Reporting Areas for Blindness Statistics" — a program to meet the increasing need for uniform, reliable and comparable statistics on the problem of severe visual impairment among the nation's population. This Model Reporting Area is a voluntary association of states which maintain registers of blind persons, and which have joined together in a pioneering and cooperative effort to collect uniform information so as to arrive at comparable and meaningful statistics on blindness of benefit to the states themselves and to the nation as a whole.

In addition, the Committee advised Doctor Fitting on the hiring of an MD to serve as the State Supervising Ophthalmologist.

The Committee continued its liaison with the Bureau in an advisory capacity and broadened its scope of activity to add the study of what is available in Michigan for visually handicapped children. Two problems are involved: (1) how to identify these children; and (2) how to give them proper aid.

In taking on this additional activity, the Committee adopted the following recommendation which has been approved by The Council: "The Committee on Eye Care requests the approval and support of The Council in promoting a study of the aid and facilities available in Michigan for the education, training and medical psychological rehabilitation for the visually handicapped, the financial aspects of such a study to be the responsibility of the Bureau of Maternal and Child Health of the Michigan Department of Public Health."

The Committee advised R. G. Rice, MD, on the future direction of his department in regard to its vision program by recommending that the Bureau drop off certain sections of its school vision testing and place more emphasis on the pre-school vision testing program, if a choice must be made.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, received this report for information.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON HOSPITAL RELATIONS

Harold H. Hiscock, MD, *Chairman*

This Committee is responsible for combining medical and hospital interests to improve health care at minimum hospital costs. Its responsibility is to the rules and minimum standards for hospitals, principles of hospital-physician relationships and hospital-physician responsibilities.

No matters were referred to this Committee for deliberation and, therefore, no meetings were held during this past year.

In 1966 this Committee sought to establish means and mechanisms by which MSMS could survey, when requested, quality of care in hospitals. The Council and the 1966 House of Delegates concurred in these recommendations and the House appointed a Committee on Medical Staff Survey of Hospitals.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, received this report for information.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON INTERNATIONAL HEALTH

Hira E. Branch, MD, *Chairman*

Physician Placement Service. The AMA is currently running a physician placement service which sends information to doctors about organizations which will sponsor them if they wish to work overseas.

The Committee on International Health continues to encourage physicians who wish to serve overseas, but will no longer be doing specific placement service since the AMA has a department in this area.

Interested physicians can either write directly to the AMA International Physicians' Placement Service or to the MSMS International Health Committee and their names will be forwarded to the AMA for quick referral to possible sponsoring organizations and areas of overseas work which is available.

Need for More Medical Aid to South Vietnamese Civilians. The Committee's research has discovered that out of a 1967 Vietnam budget of $24 billion only $50 million was alloted to medical care of the civilian population. This $50 million is intended to cover everything from basic construction to vaccinations.

Vietnam has suffered 200,000 deaths and one million casualties in the last ten years. The Committee feels that the present budget is inadequate. If only 1% of the budget were devoted to medical care of civilians, it would have to be increased to $250 million. Even this would not be nearly enough in a land suffering not only from the ravages of a long war but from countless diseases.

The U.S. is missing an opportunity to fight the "Second War" because committee members have personally experienced how good medical care can win the friendship and allegiance of the Vietnamese people. This "Second War" is crucial because without the support of the people military victory would simply be conquest, and that is not the kind of victory we are seeking in Vietnam.

A concern of the Committee on International Health, therefore, has been to alert physicians and the general public to the inadequate level of medical aid being given to the South Vietnamese population by the United States government.

With the approval of The Council, the International Health Committee is recommending AMA delegates from Michigan introduce a resolution calling for much more medical aid to South Vietnamese civilians and is working with the Public Relations Committee to plan a public information program to alert the people of Michigan to this problem.

Other Matters Relating to Vietnam. The Committee also feels that (a) whenever possible medical construction in Vietnam should be designed for permanent use, and (b) long term treatment of American war casualties is best done at the patient's home or home hospital whenever possible.

International Health Conference at the Annual Session. A panel on International Health was planned for the Annual Session so that interested doctors could learn from the experience of the committee the opportunities available to them for work overseas.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, received this report for information.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH MICHIGAN CRIPPLED CHILDREN COMMISSION

A. C. Stander, MD, *Chairman*

This Committee has been inactive during the past year.

The Michigan Crippled Children Commission no longer exists. When the reorganization of the Executive Branch of Michigan State Government took place, the then MCCC was transferred to the Department of Public Health as a "Type 2" transfer which meant that the Commission then became an advisory group to the Director of Public Health. Since then, MCCC has been integrated within the Department of Public Health and has dissolved.

Because the responsibilities and functions of the MCCC have now been taken over by the Division of Services to Crippled Children of the Department of Public Health, the Chairman respectfully recommends the dissolution of the Liaison Committee.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended approval of the report.

THE HOUSE adopted the report of the Reference Committee.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles-Meyers, MD, Chairman, having considered the same committee report, recommended, "That a special committee of MSMS be formed for the purpose of coordinating the case of the handicapped child (the crippled and afflicted children) with the State Health Department and any voluntary agency involved with the care of these children. This committee shall be composed of representatives of all interested medical groups."

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

R. V. Daugharty, MD, *Chairman*

No matters were brought to the attention of this Liaison Committee that required a meeting.

The purpose of this Liaison Committee is to meet with members of the pharmaceutical profession to consider and act upon matters of vital interest and concern to both professions. In 1966, the Liaison Committee acted in concert with the MSPA in a joint endeavor to develop a physician-pharmacists code of understanding. Mutual agreement could not be reached and the effort failed. The Liaison Committee will perform its assigned responsibilties and duties when the occasion arises.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended this report be received for information.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH RESIDENTS, INTERNS, MEDICAL STUDENTS

NORMAN D. HENDERSON, MD, *Chairman*

The Committee on Liaison with Residents, Interns, and Medical Students arranges for the participation of students from the medical schools at Wayne State University and University of Michigan at the MSMS Annual Session when it is held in Detroit.

Since the Annual Session is held in Grand Rapids this year, the Committee did not meet and has deferred action until 1968 when the Annual Session will be held in Detroit.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended acceptance of the report for information.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE BAR OF MICHIGAN

W. M. LEFEVRE, MD, *Chairman*

This Committee has the following three matters under active study with the State Bar of Michigan, and will report its findings and recommendations to The Council as soon as its work is completed.

Definition of Disability. As directed by The Council, the Committee is implementing a request from the Committee on Respiratory Diseases to consider the problem of resolving the difference between "legal" and "physical" definitions of disability, and to set up criteria upon which the disability determination will be made.

Consideration of the Establishment of a Medical Advisory Committee to the Workmen's Compensation Department. The Committee is studying the ramifications of House Bill 3120, which would establish a Medical Advisory Committee to the Workmen's Compensation Department.

Remuneration for Physicians in the Event of Testimony Cancellation. The Committee is seeking a solution to the problem that arises when a physician is requested by an attorney to testify in a particular case, and after making extensive preparations, has his scheduled court appearance cancelled with no remuneration for his efforts.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended this report be received as an interim progress report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE BOARD OF REGISTRATION IN MEDICINE

K. H. JOHNSON, MD, *Chairman*

This Committee met on March 2, 1967, with a majority of the Board of Registration in Medicine in attendance. In discussing Resolution 34 of the 1964 MSMS House of Delegates, which dealt with the adequacy of the enforcement power of the State Board of Registration in Medicine, the following statement was incorporated within those minutes as an added protection to the rights of an accused individual:

> "In order for the Board of Registration in Medicine to conduct a fair and legal hearing, the individual against whom a complaint has been lodged shall have the right to be present before the Board and shall also have the right to have legal counsel at the hearing, should the accused individual so desire."

The Committee discussed the Medical Practice Act, medical incompetence, and the Board's power to determine medical incompetence.

The Committee reviewed the relationship between the Board and Michigan medical schools regarding the schools' request for information from county medical societies and the Board in disciplinary actions taken; and a desire by the schools to have members of the Board appear before the student body and discuss problems with which the Board must deal.

The Committee also discussed the newly realigned investigative activities of the Michigan Department of Licensing and Regulation under an Administrator.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, noted that through this Committee's deliberations, added protection has been provided for an accused individual by acknowledging his right to have legal counsel at the hearing.

No conclusions have been reached on the Medical Practice Act. This appears to be an urgent issue, and a plea is again made for an early finalization of this business.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE EXECUTIVE OFFICE

KENNETH H. JOHNSON, MD, *Chairman*

It has long been deemed essential that MSMS maintain an open line of effective communication with the Governor of Michigan and his executive staff, so that these public officials may be fully aware of the policies, projects and goals of the Michigan State Medical Society as developed by its House of Delegates and Council.

This Liaison Committee is charged with fulfilling the foregoing responsibility and, on a regular basis, it has conferred with Michigan's Chief Executive or his associates on a wide variety of matters, including gubernatorial appointments, establishment of councils, study groups and advisory bodies, implementation of state and federal laws and the analysis of proposed health legislation before the State Legislature. The Liaison Committee acts only after MSMS policy has been established and each of its actions is thoroughly reported to The Council.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, recommended acceptance of the report noting "with pride the apparent excellent rapport that exists between our liaison group and the office of the State's chief executive. This channel of communication concerning MSMS policy is of extreme importance."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON THE MEDICAL ASPECTS OF ORGANIZED ATHLETICS

JAMES S. FEURIG, MD, *Chairman*

The Committee this year has sponsored a conference and dealt with several subjects related to athletics and medicine.

A "Conference on the Medical Aspects of High School Sports" was sponsored in Ann Arbor May 25, with the cooperation of the University of Michigan Department on Postgraduate Medicine. A total of 282 physicians, coaches, and trainers registered and an additional 25-50 medical students and physicians attended one or more sessions. (The attendance in 1966 was 67). Speakers discussed topics of value to team doctors, coaches, and trainers; and three trainers demonstrated taping techniques.

The Council, MSMS, has approved a Committee recommendation that the 1968 conference be held at Wayne State University in conjunction with the WSU Centennial.

The Committee worked closely with the MSMS Public Relations Committee to sponsor an educational-public relations effort in August and September, 1966 to focus attention on the Medical Aspects of Sports. The MSMS Committee encouraged and assisted several component medical societies to sponsor conferences on the local level for doctors, coaches and trainers. Public relations activities included news releases, a cover and articles in *Michigan Medicine*, etc.

MSMS printed a handsome "Certificate of Appreciation" for component societies to award to local team physicians. Such awards have been made by a number of county societies.

In other action, the Committee:

1. Presented recommendation to the Michigan High School Athletic Association to provide safety measures for interscholastic high school skiing.
2. Studied possible improvements in the physical examination form used by the Michigan High School Athletic Association for all sports.
3. Considered possible sponsorship of conferences to assist school trainers.
4. Studied regulations of the State Department of Social Services regarding physical examinations for Michigan camps.
5. Provided three Committee members as speakers for the 1967 annual meeting of the Michigan Association of Directors of Physical Education.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, commended the Committee for its attention to an area in youth development where direction can protect and prevent injury. This fine relationship with young people should be a continuing concern.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICINE AND RELIGION

Winslow G. Fox, MD, *Chairman*

The Committee hosted 27 doctors and clergymen at a Medicine and Religion Workshop for county society chairmen on March 1, 1967, at MSMS headquarters.

The sessions included a review of purpose and goals by Robert L. Coons of the AMA Department of Medicine and Religion, a progess report from each Medicine and Religion Committee chairman present, and a presentation by Paul B. McCleave, LLD, Director, AMA Department of Medicine and Religion.

In addition, the doctors and clergymen participated in a series of dialogues on moral and ethical issues facing doctors today. Among topics discussed were: unwed mothers, family life education, does man have a moral right to die, and abortion.

The Committee members will assist in organizing additional county committees and encourage programming of at least one Medicine and Religion Medical Society meeting annually devoted to the several topics of interest and concern.

The Chairman expressed his deep thanks for the work done by members of the Medicine and Religion Committees on both the state and local levels.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, received this report and acknowledged its fine work, urging continuation of the workshop discussions between medicine and the clergy.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MICHIGAN MEDICAL HISTORY

J. R. G. Gosling, MD, *Chairman*

This new Committee held its first meeting and has started its early work.

The Committee adopted two general goals: (1) to research and write about medical history in Michigan, and (2) to encourage such work on a county level.

Efforts were started to encourage component medical societies to appoint a chairman and/or committee to work on the local level. Many counties have named such committees.

Plans were explored to hold a *Michigan Medicine* cover contest about Michigan Medical History among the art students at one or more colleges.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, received this report for information.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON NURSING

Robert L. Tupper, MD, *Chairman*

The Committee on Nursing was moderately active this past year. The Committee had several new members as well as a new Chairman and consequently spent some time reviewing recent accomplishments of the Committee and the Committee's general philosophy.

Considerable effort was devoted to a continuing discussion of the concept of dependent and independent nursing functions as manifested in the Joint Statement prepared by this Committee during 1965-1966. In particular, a specific problem referred to the Committee during the course of the year was discussed. This problem dealt with the performance of vaginal examinations by nurses in the hospital to follow the course of labor. The Committee concluded that, as new areas such as this develop, our best guideline is to advise that activities such as this be permitted where the medical staff is willing to provide adequate instruction and supervision to the nursing staff and where the nursing staff is willing and capable of performing these functions.

The Committee considered 1966 House of Delegates Resolution 39 on the Nursing Wage Scale and initiated correspondence to appropriate authorities in this regard. As a consequence, the Michigan Nurses Association has offered to furnish their brochure, "Recommended Qualifications and Employment Standards for Professional Nurse Positions," to all MSMS members upon reqeust.

Another major area of activity by the Committee has been pursuit of the concept of organizing a dialogue between doctors and nurses at the state level in Michigan similar to the three successful dialogues recently sponsored by the AMA and ANA on a national basis. A subcommittee has been appointed and is exploring the merit and feasibility of this in Michigan.

Finally, considerable discussion was devoted to how to establish a better understanding by physicians of the position papers on nursing education by the American Nurses Association and the Michigan Nurses Association. As an outgrowth of this Committee's efforts, an article written by two nursing members of the Liaison Committee on this subject appeared in *Michigan Medicine* this past fall. It was also recommended that liaison committees of medical societies and district nursing associations explore this matter at the local level.

The Committee hopes to develop some of the above areas to a greater degree in the coming year as well as to undertake consideration of problems such as nursing functions and coronary care units and other special situations.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, received the report for information, commending the Committee for its interest and aid in resolving problems realized at intervals in the nursing profession.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON REHABILITATION

R. W. Pomeroy, MD, *Chairman*

Education. The Committee recognized the value and need for including in all MSMS postgraduate and scientific programs more subjects related to chronic diseases and rehabilitation. The Council has approved the Committee's recommendation that the Committee on Program for the MSMS Annual Session include in its scientific program at least one discussion in the field of rehabilitation.

In addition, the Committee will cooperate with the Mary Free Bed Rehabilitation Complex of Grand Rapids in sponsoring a scientific exhibit at the 1967 MSMS Annual Session. In this exhibit, the Committee's Directory of Michigan Medical Facilities will be displayed and distributed on a request basis.

Rehabilitation Nursing Techniques. Under study by the Committee has been the generalized lack of application of rehabilitation of nursing techniques in general hospitals throughout the State of Michigan. The fact that rehabilitation nursing techniques are not used as extensively as they should be may reflect a shortcoming in one of the following areas:

A. Failure to develop an adequate teaching-learning situation in the various schools of nursing;

B. Insufficient time in the working situation to carry out techniques known to be of value;

C. Failure on the part of supervision to insist upon, or at least encourage, the use of such techniques in practice;

D. Inadequate in-service training and rehabilitation nursing techniques in order to standardize such procedures for all nursing personnel; and

E. Lack of awareness that such techniques exist.

A questionnaire has been developed and has been distributed by members of the Committee to directors of various schools of nursing in Michigan, in order to compile factual information regarding course content and student experience in rehabilitation. During the summer months, the questionnaire will be distributed to in-service education directors of hospitals and directors of nursing services and practical nurse services, to complete the understanding as to present practices. During the next year, members of the Committee will review the completed questionnaires.

The recommendation of the Committee, which has been approved by The Council: "That, in view of the situation of nursing homes providing physiotherapy services under the pressures of Medicare, a method be considered whereby physical therapy is made a part of medical treatment and whereby the patient's physician is made the person directly responsible for ordering specifically the kind of physiotherapy to be given to a patient whether this patient is in a hospital, a nursing home, or in any other facility," will be presented to the 1967 House of Delegates in the form of a resolution since the Committee realizes its recommendation has to be implemented through education on the county level.

Exhibit. During the summer months, the Committee will cooperate with the Michigan Health Council in setting up an exhibit on rehabilitation careers for the Career Mobile.

Government Programs. The Committee is concerned over how physicians can take a more positive interest in, and participation in, the proposed government programs in relation to rehabilitation and the treatment of chronically ill persons. The need for making our importance known and how to make an impact on the type of programs that are and will be propounded, the need for improving the position and liaison of this Committee, and possibly the State Society as a whole was also discussed by the Committee.

Practice of Physical Therapy. Now that there is a new law in Michigan governing the practice of physical therapy, the Committee is concerned that the physical therapists now in practice are doing so within the limitations of the new law.

The Committee has recommended that a copy of the Physical Therapy Practice Act be sent to the presidents of Michigan's component societies with the request that the county society check to see that all practicing physical therapists in their local area are licensed. If any are found to be practicing without a license, it is the Committee's recommendation that these violations be reported in accordance with the law.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, reviewed "the fine report" and concurred in its recommendations.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RELATIVE VALUE STUDY

B. R. VAN ZWALENBURG, MD, *Chairman*

In accordance with the action of the 1966 House of Delegates the 1967 Committee continued the study of the Michigan Relative Value Scale.

The continued advisability of maintaining a Relative Value Scale as a guideline for payments by third parties was noted although the Committee advises The Council of its opinion that use of the usual, customary and prevailing fee concept for determination of payments by insuring agencies is more equitable than the use of a schedule.

The Committee reviewed the initial edition of the Current Procedural Terminology developed by the American Medical Association. This is a new effort to produce a single system of coding and description of services for nation-wide use. It is the opinion of the Committee that conformity with the AMA Procedural Terminology will be necessary and advisable when that work has been further refined but its development is not completed and is still under active revision by the AMA. Consideration of altering the Michigan Relative Value Scale to match the AMA Current Procedural Terminology was therefore deferred and is recommended for future study.

The major work of the Committee was in accomplishing a revision of the Section on Medicine, as advised by the previous year's Committee, with special attention to the Visits and Consultation sections.

The aim of the relative value scale system was defined by the Committee as the production of a machine pattern by which any physician can, as far as possible, find a code number and relative payment recommendation corresponding to his usual and customary fee, together with a wording which will describe his services to insuring agencies with sufficient specificity to justify payment. This is particularly difficult to achieve in the Visits section which covers a very wide range of types of services and types of practices. The categories are therefore defined by the amount of service rendered and the type of service is indicated only as a comparative graded measure. Since the scale is developed for medical practice as a whole it must be used in that context (i.e. an investigation which is of a "routine" type for specific physician or specialty may be "extended" when regarded from the viewpoint of medical practice in general and should therefore be considered as "extended").

The Relative Value Scale, as revised, is submitted herewith. The Committee recommends that the 1965 Michigan Relative Value Scale, as revised in 1967, be submitted to the House of Delegates and that, in accordance with prior custom, copies be sent to the Delegates for study before the Meeting of the House of Delegates.

The Committee met with representatives of the Michigan Academy of General Practice and the Michigan Society of Internal Medicine and expresses gratitude for their important aid. Help was also received by correspondence with representatives of other specialty societies involved in the section on Medicine.

The Committee expresses deep appreciation for the efficient services of Mr. Richard Campau as Staff Assistant.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, reviewed the 1967 RVS changes recommended by the RVS Committee and discussed them in detail with the Chairman. The Reference Committee's intent was to approve the 1967 Relative Value Study, but through a technical difficulty it did so only

indirectly by means of other reports. (See Reference Committee action on the Report of the House of Delegates Committee to Study the Monetary Value of the RVS.)

Subsequently The Council, at the request of the Speaker, approved the 1967 Relative Value Study as reported in the Annual Report of the Relative Value Study Committee and distributed to the Delegates, in order to clarify and formalize the intent of the House of Delegates as determined by a thorough review of the transcript.

COMMITTEE ON WORKMEN'S COMPENSATION

William Jend, Jr., MD, *Chairman*

This Committee was created by The Council upon recommendation of the MSMS Occupational Health Committee that a special group be appointed to work toward strengthening and improving the medical aspects of the administration of Workmen's Compensation.

Through the efforts of Committee members, House Bill 3120 was introduced in the 1966-67 legislative session. This Bill incorporated, as amendments to the Workmen's Compensation Law, the recommendations of this Committee which were adopted by The Council. This is the first specific legislative action taken toward implementing the recommendations of this Committee and represents a real milestone.

This legislation did not get out of Committee during this session. However, the Committee is planning to have the bill introduced in the fall and a major effort to enlist full MSMS support, as well as that of other interested health groups, will be made.

A member of the MSMS staff is a former employee of this state agency and is acquainted with and keeps liaison with the administrators of this agency.

The Chairman feels that this Committee should continue since there is a possibility that the desired legislation may again be introduced.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, James C. Danforth, MD, Chairman, received the report, congratulated the committee on its work, and recommended continuity in the Committee's actions.

THE HOUSE adopted the report of the Reference Committee.

16. Annual Reports of Standing Committees

ADVISORY COMMITTEE TO THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

G. E. Millard, MD, *Chairman*

There were no formal meetings of the Advisory Committee to the Michigan State Medical Assistants Society within the past year although attendance of the advisors has been excellent at all of the important meetings of the Medical Assistants Society, and members of the Advisory Committee have been called upon for advice and counsel.

Informally, the advisors have been concerned because of the lack of growth of the Medical Assistants Society within the past few years and there is a general feeling of the advisors and officers of the Society that some way must be found, on a county and state level, to increase the exposure of the local physician to the existence and support of this organization.

During the 1966 meeting of the House of Delegates of MSMS, the Reference Committee on Reports of Officers recommended that all members of the House of Delegates and all other physicians in the State encourage their assistants to join this organization. The House adopted this report and had this suggestion been carried out, many new members of MSMAS would have been added.

The Board of Directors of MSMAS has authorized the appointment of a "Projection Committee" to make recommendations, among other things, of methods of increasing the membership of the Society and the Advisory Committee will be of as much help as possible when this report is ready for implementation.

Within the next few months, members of the Michigan State Medical Assistants Society will be distributing the very attractive brochure, "Winning Ways with Patients."

The Advisory Committee feels that physicians will find this brochure most helpful in the training of their office personnel to better serve their patients.

The American Association of Medical Assistants will be meeting in Los Angeles in October and as usual Michigan will be well represented. Michigan members hold several very prominent positions of leadership in the AAMA. For more information about the work and worth of MSMAS, may we refer you to the annual report of the president which is included in the delegates' notebook.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, commended this committee for its continued efforts in improving public relations and education of medical assistants. The Committee drew attention to the publication, "Winning Ways With Patients," strongly urging every physician to acquaint himself and his assistants with the contents of this manual.

THE HOUSE adopted the report of the Reference Committee.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Bradley M. Harris, MD, *Chairman*

No problems of policy relative to the Woman's Auxiliary arose during the year so it was not necessary to call a formal meeting of the Advisory Committee. The chairman and one other member of the Committee held several informal meetings with the president of the Auxiliary and all members of the Committee were available at all times for advice and counsel.

The good work of the Auxiliary will be reflected to a degree in the Annual Report of the President of the Auxiliary before the House of Delegates, and in her written report which is included in the Delegates' Handbook. However, it is impossible for us to assess from these reports, the good that the Auxiliary is doing to assist the doctors of Michigan, particularly in the fields of public relations and community service.

The leaders of the Woman's Auxiliary are concerned that the wives of all physicians are not members of their organization, since the need for participating members is so great and they would like to have all doctors and their wives know that the wives would be most sincerely welcomed into membership in the Auxiliary.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, presented the following report:

"The Reference Committee strongly supports the recommended plans in this report to attract more doctors' wives into active service in the Woman's Auxiliary. Your Reference Committee wishes to extend its commendations to all of those loyal wives who serve with unending devotion in support of those principles which we as physicians hold dear to our hearts in the provision of medical services.

"Your Reference Committee recommends that this report be accepted."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AGING

A. Hazen Price, MD, *Chairman*

Our Committee met in December and discussed implementation of Medicare and Medicaid, the Older American Act, and a possible regional meeting of Nursing Home Operators and others.

It was agreed that additional time and experience with programs of Medicare and Medicaid were needed before making recommendations other than those discussed during the meeting.

A joint meeting of members of the Committee on Aging and the Michigan Society of Gerontology was sponsored and held in May at the Saginaw County Hospital. More than 150 nursing home personnel attended from different parts of the state for a spirited presentation and discussion of new patterns in the care of persons in nursing homes and homes for the aged.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The importance of the work in this field was recognized. We recommend the careful analysis by this Committee of the various programs now extant in the field of geriatrics, and we would like a report on their studies next year. We commend this Committee and encourage them in their continued work."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON BLOOD BANKS

L. W. Gardner, MD, *Chairman*

While formal meetings were not held by the Committee on Blood Banks, adequate contact was maintained between members by letter and telephone.

Members of the Committee worked with those of the Blood Bank Committee of the Michigan Society of Pathologists and introduced in the Michigan Legislature, a bill declaring blood a "service." This bill specifically excepts blood transfusion from the provisions of the Federal Trade Commission and the Michigan statutes dealing with product warranty. The bill passed both the House and the Senate. This statute is a significant forward step for all members of the medical profession, hospitals and donors since they will not be subject to liability for breach of "implied warranty." Only a few states have adopted similar legislation.

The Committee is in the process of investigating the feasibility of establishing a Central Registry for Reporting Donors Involved in Cases of Homologous Serum Hepatitis.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The bill introduced in the Michigan Legislature declaring blood a 'service' was commended. Since it removes blood transfusion from the provisions of the Federal Trade Commission, we commend the fine liaison work which this Committee has performed."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON CANCER

M. E. Dodds, MD, *Chairman*

Heart-Cancer-Stroke. The Committee has recommended that MSMS organize a meeting of scientific committee chairmen and others interested in heart-cancer-stroke, in order to allow these persons to discuss the part to be taken by MSMS in the many plans now being made.

Cervical Cancer. The Committee is concerned with the many deaths resulting from cervical cancer and the lack of interest on the part of physicians and patients to utilize the Pap smear test as a means of early diagnosis of this disease. Inasmuch as the Social Welfare Department will not pay for diagnostic tests, but only for treatment, the members of the Committee feel that many women receiving financial aid from the state are at a disadvantage and that, if a Pap test could be given to these women, this would be a great source of early diagnosis of cancer of the cervix.

The following recommendation of the Committee has been approved by The Council:

"Inasmuch as the major segment of the adult female population in the State of Michigan has not had a Pap test, that the Committee on Cancer be authorized to re-emphasize the importance of this procedure as a public health measure, and urge all related health agencies, communities, physicians, nurses and hospitals, to utilize whatever facilities they have in their local area, to improve this situation."

Statement on Smoking and Cancer. The following statement on cancer was adopted by the Committee on February 8, 1967:

"The Committee on Cancer of the Michigan State Medical Society recognizes that control of smoking is an area in which doctors of medicine can be effective in the control of cancer." Subsequently, this statement was also adopted by the Michigan Cancer Coordinating Committee.

Michigan Cancer Coordinating Committee. The MSMS representatives to Michigan Cancer Coordinating Committee reported that the MCCC has a professional education program. The program consists of providing speakers on cancer for meetings of Michigan's county medical societies and the Michigan dental districts, as well as at the annual conventions of the Michigan State Medical Society and of the Michigan State Dental Association.

Other subjects discussed by the Committee were: the status of clinical laboratories in Michigan; the hospital-based cancer programs of the American College of Surgeons; the member-organizations of the Michigan Cancer Coordinating Committee; and the program of the Michigan Council on Smoking and Health.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The Reference Committee wishes to commend this Committee for the work done during the year, and to urge The Council to implement the Resolve regarding heart, stroke and cancer programs, to the effect that MSMS organize a meeting of scientific committee chairmen and others interested in Heart-Cancer-Stroke. This would allow these persons to discuss the part to be taken by our Michigan State Medical Society in the many plans being introduced."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CARDIAC DISEASE CONTROL

S. E. Chapin, MD, *Chairman*

Rheumatic Fever Control Center. The Committee is of the opinion that a point has been reached when the Rheumatic Fever Control Centers, as directed by the MSMS, could be abandoned. Therefore, The Council approved the recommendation of the Committee that the Rheumatic Fever Control Program, as a part of MSMS activity, be discontinued. The Committee has no objection to some other organization continuing this activity.

Michigan Heart Association. The Committee continued its liaison with the Michigan Heart Association and heard reports on the various programs and activities of this organization.

In addition, The Council approved the Committee's recommendation that the proposed Rheumatic Fever Emphasis Program of the Michigan Heart Association be endorsed by the MSMS. The MHA Program coincides with the interest and goals of the one-time MSMS Committee on Rheumatic Fever Control.

Screening Tests. The Committee forwarded the following statement to the special study committee of The Council reviewing the matter of screening tests: "With regard to screening programs, the Committee on Cardiac Disease Control indicates that certain screening programs have shown desirable results. The Committee endorses the concept of early recognition of disease and the identification of risk factors leading to overt disease. The Committee recognized that there are significant problems associated with screening programs.

"The Committee recommends that screening programs be carefully constructed with particular reference to the following guidelines:

A. That there be well defined objectives and that they be realistic and obtainable.
B. That these objectives be so constructed that degree of achievement can be evaluated.
C. That disposition and follow-up for abnormal results be carefully planned.
D. That it provides data on the cost effective basis of screening.
E. That initial efforts be oriented to demonstration projects, feasibility studies, simplification of procedures, and identification of problem areas, prior to embarking on any major programs.

"Within these limitations, the Committee on Cardiac Disease Control is in favor of further exploration by interested agencies in the field of cardiovascular screening, preferably as a part of a multi-phasic screening program."

Closed Chest Cardiac Resuscitation and the Nurse. Upon recommendation of the Committee, The Council approved the following statement: "That counter-shock of patients with life-threatening arrhythmias, by properly trained nurses, be permitted when the circumstances have been approved by the hospital and the medical staff where the nurse is employed." The Committee has recommended the adoption of similar policy statements by the Michigan Hospital Association and the Michigan State Nurses Association.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The Reference Committee moves to accept this report with commendation for its content and detail. We especially approve of their efforts in cardiac resuscitation programs."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON CHILD WELFARE

John M. Dorsey, Jr., MD, *Chairman*

Summer Camp Examination. In discussing the problem of unrealistic summer camp physicial examination data requirements, the Committee adopted the following recommendation: "That 1) if a physical examination had been given the child within a period of six months; 2) if the child's immunizations are current; and 3) if a child has not been exposed to recent communicable disease, such examination of six months' duration be considered adequate to cover the requirement of a physical examination prior to entering summer camp. This examination is not to exclude the health inspection given on the day the child enters the camp."

Wrestling Weights. The Committee reviewed the problem of wrestling weights and the apparent need for some sort of statement from the Committee. The following statement on wrestling weights has been approved by the Committee and referred by The Council to the Committee on Medical Aspects of Organized Athletics, for its consideration. When the statement is approved by The Council, it will be transmitted to the Michigan State Division of Athletics.

The statement reads: "In considering sound direction in weight control for high school students involved in wrestling, the Committee on Child Welfare of the Michigan State Medical Society, advises all members of the Society that inasmuch as the problem of wrestling weights varies according to the student, no definite standards of weight be set up and that the integrity of the coach be considered as paramount in making the decision as to the best wrestling weight for each child. In addition the Committee recommends that physicians be available to serve as advisors to coaches on the matter of wrestling weights when this service is requested."

The Committee reviewed the work of the Committee on Eye Care; the Oakland County pilot study on physician communication with local people on school health problems; measles immunization and rubella testing; family life education; child abuse law; minimum standards for hospitals; legislation; and perceptual handicapped children.

The Committee has continued its good liaison with the Bureau of Maternal and Child Health of the Michigan Department of Public Health.

THE REFERENCE COMMITTEE on Repors of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"Your Reference Committee commends this Committee for their increasing interest in elementary and secondary school athletics. We also commend them for their work on the study of visual problems."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON DIABETES

William M. LeFevre, MD, *Chairman*

The Committee on Diabetes held one meeting on November 16.

The Committee is concerned that there has been no contract between the sponsoring agencies of the Michigan Diabetes Detection Program, the Michigan Diabetes Association, the Michigan Department of Public Health, the Michigan Society of Pathologists, and the Michigan State Medical Society.

The Committee would like to see more diabetes education of physicians and the public, with more research in regard to this disease and a lessening in keeping of statistics and reports.

Through the joint efforts of several county medical societies, the Michigan Diabetes Association, the Michigan State Medical Society through its Committee on Diabetes, and the Michigan Department of Public Health, detection programs were conducted in various localities. The actual number of individuals tested will not be available until the end of the calendar year, but it is quite evident that many possible diabetics were found and referred to their family physicians for diagnosis and treatment.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"Your Reference Committee wishes to commend this Committee for their work, and to emphasize the educational material which they are sending to physicians and the public."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON GOVERNMENTAL MEDICAL CARE PROGRAMS

P. T. Lahti, MD, *Chairman*

One of the first reports received by this Committee was the successful negotiation between the Office of Dependents Medical Care (now known as Civilian Health and Medical Program of the Uniformed Services - CHAMPUS) and MSMS for the period from November 1, 1966 to October 31, 1967. Under this program, reimbursement to physicians for the rendering of services will be by using the 1965 MRVS, amended 1966, with the $5 conversion factor for maximum allowances.

The Council directed this Committee to meet with the entire Medical Advisory Committee of Michigan Medical Service and to report to The Council answers to the following questions:

1. What is the screen established for use in connection with doctors' charges?

2. How was a screen established, and by whom?
3. How do payments to physicians under the method described in the November 9 report compare with those provided by the Michigan Relative Value Study (scale) of 1965 as revised in 1966 and approved by the 1966 MSMS House of Delegates?
4. Why is MMS *not* using the 1965 MRVS, with a conversion factor of not less than $5, as a guideline in accordance with MSMS policy regarding all governmental programs?

The Chairman issued an invitation to the MAC to a joint meeting to answer the above questions. A response stated "Any such meeting is both inappropriate and impractical at this time." The Committee then discussed the possibility of meeting with the MAC in January, 1967. An invitation extended to the Chairman to attend this MAC meeting as an observer was accepted.

The Committee was authorized by The Council to request an increase in the inpatient surgical schedule portion of the V.A. Hometown Care Program contract from $3.80 conversion factor to $5.00. The VA agreed to the requested increase.

The Committee has been involved in physicians' reimbursement for services for less than the physician's submitted fee under Medicare and Medicaid. The Committee made the following recommendation: "That, while this Committee has the overall responsibility to concern itself with all areas of federal and state medical care programs, specific complaints be referred to the already established County Blue Shield Medical Advisory Committees through the Chairman of the Medical Advisory Committee of Michigan Medical Service."

The Council did not approve this recommendation "until the Committee has an opportunity to discuss this and other problems with the MMS Medical Advisory Committee."

A report of the Chairman's attendance at a meeting of the Medical Advisory Committee of Blue Shield Board of January 11, 1967 was given. A review was made on administration by MMS under Title XVIII of Medicare which read "The screen is a composite of all available charge data with the MRVS serving as a focal point for physician's charges. If the physician's charge on a claim falls at or below the MRVS guideline, it is paid as billed." It was the Committee's feeling that this "screen" was being used as a ceiling and as a fee schedule and is not the intent of this Committee or the law. The Council adopted the Committee recommendation: "That the 1965 MRVS at a $5 conversion factor, subject to yearly review be a guideline for physician's payment under Titles XVIII B and XIX with the understanding that customary, prevailing, and reasonable fee *may vary*, according to the physician's training, experience, and geographical location. After one year a review of the experience of the entire program will be made."

The Chairman reported that he had had a meeting with the Director of the Professional Relations Division of MMS to review the unpaid physicians' claims that had been submitted. All claims were adjusted upward with one exception.

A review of the Federal "Comprehensive Health Planning and Public Health Services Amendments of 1966" was made. Comparative alternatives regarding the feasibility of selecting either a single state agency or an interdepartmental agency to administrate this program were discussed. The Committee adopted the suggestion of a "Plan for Planning Committee" which was transmitted to the Executive Office on an informal basis. Later, a formal transmission was made by letter.

This Committee was requested to interpret and take initiative action on resolutions referred to the House of Delegates. Resolution 15 dealt with utilization of medical societies' committees for Medicare complaints and The Council adopted the following recommendations: "The Committee interprets this resolution to mean that when a hospital or a fiscal carrier receives a complaint regarding competency or quality of medical care, the hospital or the fiscal carrier should refer a complainant to the local county medical society in which the physician holds membership."

Resolution 29 enunciated the concept of physicians' and surgeons' "usual and customary fees." The Council requested a determination as to the appropriate governmental units to receive this communication. The Committee made the following statement as an opinion: "That the intent of this Resolution has been implemented and is continually being implemented to the fiscal carrier and to all governmental agencies."

A joint meeting with representatives of Michigan Medical Service was held. This Committee was assured by MMS that physician profiles will be established according to *actual charges* made by the physician and *not* according to what MMS pays and that a true profile of physician's charges cannot be compiled until at least January 1, 1968.

MMS stated that it is trying to be fair and reasonable to the physician while complying with the Federal regulations as established by HEW. The Council urged the Committee to press for its position on the 1965 MRVS, as amended.

Representatives of the Social Security Administration addressed the Committee and emphasized their desire for better liaison and rapport between SSA and the physician and offered the services of their offices to the medical profession in every possible manner.

This Committee received requests for the Michigan Uniform Fee Schedule for Governmental Welfare Agencies (Red Book) from MD's, DO's, dentists, and hospital administrators. Staff was instructed to determine the state agencies that require the use of this Red Book and found that it is used in several state agencies.

The Committee discussed the following alternatives:
1.) Distribute 1965 MRVS, amended 1966, (Gray Book) with a page insert stating that this, with a $5 conversion factor constitutes the most recent Uniform Fee Schedule.
2.) Remove the 1965 MRVS, as amended, cover (Gray Book) and replace it with a new cover stating that it is the 1966 Uniform Fee Schedule based on the 1965 MRVS, as amended, with a $5 conversion factor.

The Council adopted the Committee's recommendation: "In the future, payment from all governmental agencies be on the same basis as in Title XVIII B-Medicare." The Committee has also expressed this policy to the VA for FY 1968.

The physician can, by the continual submission of his usual and customary charges, determine the prevailing fee level based on the customary charge in the localities, the charge the physician most frequently makes to his other physicians for similar services, and the use of the 1965 MRVS (as amended) as a guideline for physicians' reimbursements.

Staff has conducted a number of luncheons and/or meetings with federal and state government personnel to establish the liaison necessary for the mutual and effective exchange of information. This liaison will continue and will be broadened at every level.

The Committee has contributed regularly to *Michigan Medicine* and other publications of MSMS informational articles and bulletins of interest and concern so that members can be aware and knowledgeable of the many federal/state programs now in existence and of proposed federal/state programs.

THE REFERENCE COMMITTEE on State and Federal Legislation, James D. Fryfogle, MD, Chairman, stated it was impressed with the work of the committee and recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON HIGHWAY ACCIDENT PREVENTION

P. W. Cikas, MD, *Chairman*

The Committee on Highway Accident Prevention held two formal meetings.

A continuing concern of the Committee is the need for regulations of standards for ambulance drivers, ambulance attendants and safety standards for ambulances. The Committee is cognizant of the difficulty faced by many morticians, particularly in the rural areas, of not being able to comply with a state statute due to the requirements of Medicare, the financial liability costs, the new federal standards setting minimum hourly rates, etc. Emphasis was made of the need for education and of promotion by the Michigan State Medical Society to dramatize the public necessity for properly trained personnel and properly equipped ambulances. The Council adopted the following amended Committee recommendation: "That MSMS support state legislation, if introduced, to require minimum standards of training for ambulance attendants and driver-attendants, minimum standards for the equipping of ambulances and the regulation of ambulance traffic, and further, that the Committee on Highway Accident Prevention be requested to draw up reasonable and proper standards and work with the Legal Affairs Committee in supporting such legislation.

Discussion with Representatives R. W. Davis, W. L. Jowett and R. J. Smit concerning HB 2674, a bill to establish standards for ambulance attendants and ambulances, made us aware that passage of such legislation during the present session of the legislature was not feasible.

Members of the Committee were, therefore, instrumental in the adoption of Resolution 65 by the House of Representatives which created a Special Committee on Ambulance Service in Michigan. This resolution calls for an "in-depth study of the emergency medical transportation system in Michigan and hopefully would lead to legislation which would require minimum standards for ambulance service and insure fair compensation to those who provide such service."

With Council approval, a letter was directed to the Speaker of the House of Representatives advising that the Committee and The Council strongly support House Resolution 65 and that MSMS will give every possible advice and assistance to this Study Commission. In June, the House of Representatives adopted the resolution and appointed a Committee to "study the availability of ambulance services."

Regarding the distribution of Medilabels, the Committee noted the Michigan Secretary of State had authorized these labels for distribution by physicians only and, while some distribution was being made, the bulk remain undistributed. The Committee discussed the necessity for accurate and authentic data, the proper methods of distribution and of the physician's decision as to the appropriate medical data to be added to the label. The Committee then made the following recommendation: "That The Council approve the concept of distributing Medilabels through responsible lay organizations, but that every organization receiving these labels, be instructed that information on these labels *should be authenticated by a physician.*"

The Council was cognizant of the proviso agreed to by the Michigan Secretary of State and directed the Committee to discuss this proposed change with the Secretary of State. Mr. James M. Hare replied "Whatever method is determined by The Council as to the most proper and appropriate means of distributing these Medilabels will meet with my approval."

Subsequent action by The Council is anticipated.

The 1966 House of Delegates Resolution 46 re driving license evaluation and examination was referred to this Committee for consideration. The resolved portion of the resolution requested that the Committee direct its effort toward legislation to accomplish driver examination and re-evaluation should a physician so find and ask that physicians be required to report drivers who have a disease or infirmity which would constitute a driving hazard.

The Committee was deeply concerned with the problems of physician-patient relationship; the question of liability protection for the physician; and a question of the opinion of the physician as to whether or not his patient can safely operate a motor vehicle, etc. It was this Committee's feeling that the purposes of this resolution could be better accomplished by providing immunity from civil or criminal liability for physicians who *voluntarily* report disease or infirmities that could limit the driving task to the licensing agency. The Committee also believes that mandatory reporting would violate the physician-patient relationship and could prevent the patients from seeking further medical attention. The Council adopted the following recommendation in principle: "That The Council seek to establish a Medical Advisory Board to the Michigan Secretary of State on evaluation of licenses of drivers with physical and mental handicaps."

The Committee suggested that a preliminary meeting be held, to be attended by the President of MSMS, the Secretary of State, the Director of Public Health, the Director of the Michigan State Police, the Executive Secretary of the State Safety Commission, and the Chairman of the MSMS Committee on Highway Accident Prevention, or their duly appointed representatives. The Council requested the Committee to proceed with its proposed preliminary meeting and report back to The Council with proposed guidelines to describe the role and duties of such a medical advisory board, etc.

The Council approved the Committee's recommendation urging every MSMS member to participate in programs of instruction in first-aid and the proper transportation of the injured to lay groups when invited.

The Committee has also been active in other areas relating to its designated responsibilities and functions with the staff maintaining continual liaison with the appropriate divisions of the Michigan Secretary of State and the Executive Secretary of the Michigan State Safety Commission so that a steady and constant exchange of mutual problems and information is had.

The Chairman attended a meeting of the AMA Committee on Medical Aspects of Automotive Safety in Chicago on February 4, 1967 as a representative of the MSMS Committee. The purpose of this meeting was to establish better liaison in the area of traffic safety between the AMA Committee and the various state committees. The AMA Committee anticipates an increase in importance of the work of the various state society committees in view of the issuance of recommendations to the states concerning traffic safety matters by the new National Highway Safety Bureau. The Chairman presented a resume of the activities of the MSMS Committee on Highway Accident Prevention over the past two years as summarized in the Annual Reports of our Committee. It was most gratifying to learn that the activity of the MSMS Committee over the past few years concerning specific projects has closely paralleled the acting of other state society committees and the AMA Committee itself. A final report of the Chairman's attendance at this meeting was submitted to The Council.

The Chairman commends the members of this Committee for their interest and devotion to the cause of highway safety.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The Reference Committee commends this Committee and its fine report, and wishes to emphasize its recommendations on the training of ambulance attendants and their attempts to study the availability of ambulance service. Every member of MSMS is urged to participate in programs of instruction in first-aid and the proper transportation of the injured."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON IODIZED SALT

Brock E. Brush, MD, *Chairman*

The Committee is again faced with a rising incidence of goiter and also of cancer of the thyroid. The two avenues open to us continue to be, first, meaningful advertising program to promote the use of iodized salt and, second, legislation that will require table salt sold in this state to be iodized.

Legislation is our ultimate goal since it has worked effectively and successfully in Canada, Switzerland, and Central America. In the meantime, however, we have continued our advertising programs to promote the use of iodized salt. These campaigns are expensive and need yearly re-emphasis. Our Committee felt that the cost could be met if we were able to form a Michigan Thyroid Association to accept monies from United Foundations, Torch Drives, Community Fund Drives, etc.

During the past year, the Committee reviewed its work with representatives of the Michigan Department of Public Health, the University of Michigan, the Michigan Food Dealers Association, the Michigan Chain Stores Council, the Salt Producers Association, the Michigan Association of Osteopathic Physicians and Surgeons, the Morton Salt Company, and the Michigan Dietetic Association, in an effort to set up a meaningful educational campaign on the value of using iodized salt for the prevention of endemic goiter, this special effort to be followed up by a continuing yearly educational program.

The educational program has been studied with the help of the Wallace-Blakeslee, Inc., Advertising of Grand Rapids, and would cost $20,000 for the first year's program and $2,400 per year to continue the program in perpetuity.

Early in the new Committee year, we plan a meeting with three representatives of The Council to discuss the possible programs that can be carried out by the Committee in order to accomplish our ideals.

An interesting sidelight to the problem in Michigan is that the death of so many alewives was authoritatively reported to be due to lack of sufficient iodine in Michigan waters.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The Reference Committee wishes to commend this Committee for their continuing work and excellent report. We endorse their plans and suggestions for the coming year.

"We note with dismay that there is a rising incidence of goiter in Michigan, and we must be ever mindful that we are living in a 'goiter belt.'"

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON LEGAL AFFAIRS

Otto K. Engelke, MD, *Chairman*

During the regular 1967 session of the Michigan State Legislature nearly 150 proposals for new laws were related to health care and reviewed by the Legal Affairs Committee. Over two-thirds of these were deemed to be of sufficient interest to warrant an MSMS position. When the legislative session ended 23 health bills had been enacted into law, and all had been approved by the Legal Affairs Committee.

Of the less than two dozen health proposals finally approved by the Legislature, nearly half were either bills drafted and sponsored by MSMS itself or bills which had been amended to conform with the Society's suggestions. No new legislation was enacted which had been disapproved by the Legal Affairs Committee.

Since 1967 was the first year of the two-year term of elected State Representatives, all proposals not acted upon are still eligible for consideration during 1968. Nearly eighty bills or resolutions dealing with health are thus still before twelve House of Representatives and eight State Senate committees, which will be considering many of them prior to the commencement of the 1968 session in January. Furthermore, at that time legislators will introduce many new bills.

Inasmuch as the Legal Affairs Committee cooperates with the Legislature's committees, it will continue its activities throughout the entire year.

It can be reported that the Legal Affairs Committee's efforts during the current year have been singularly successful. Health proposals are of course introduced from many sources including departments of government, organizations and individual legislators. The fact that nearly one-half of all new health laws were a part of MSMS' own program evidences the success of the Society's legislative activity. Five of the eleven bills introduced by MSMS were signed into law by the Governor.

The 1966 House of Delegates requested an amendment to the Michigan Medical Practice Act which would permit the State Board of Registration in Medicine to accept, in lieu of Michigan examination, certification by the National Board of Medical Examiners. This has been accomplished by Public Act 233 of 1967. A bill was also requested which would make it clear that there is no warranty when blood is transfused, so as to provide protection from suit in the case of transmission of undetectable serum hepatitis. The Legislature has now adopted Public Act 173 of 1967 covering this matter.

In 1966 the House of Delegates requested an amendment to the 1965 PKU test statute so that responsibility for the test would not in all circumstances be that of the physician who actually delivered the child, and Public Act 228 of 1967 now states that the physician in charge of the care of the child (or if none, the physician who delivered) is responsible for the testing. By enacting Public Act 270 of 1967, the Legislature has provided important immunity from liability for physicians who, in their hospital staff committee activities, must evaluate staff applicant qualifications or treatment data. MSMS also drafted, sponsored and was successful in having adopted Public Act 106 of 1967, which amends the Michigan Fire Prevention Act of 1941 so as to ban from home or private automobile use certain potentially deadly types of fire extinguishers.

In addition to the foregoing new laws, all drafted by MSMS, the Legislature adopted Public Act 149 of 1967, a wholly new nursing practice law, containing language drafted by the Society which will permit proper utilization by physicians in their offices of unlicensed personnel. An "implied consent" law was adopted (Public Act 253 of 1967) which, while it makes provision for the blood test for intoxication, emphasizes the use of the breath test. This new law was endorsed by the Society and contained language offered by MSMS.

The Legislature, at MSMS urging, took an important step in 1967 in adopting, by concurrent action of both its houses, Resolution 88 which calls for a study in depth of the "healing arts" and paramedical fields. The study will be conducted by members of the State Affairs Committees of the Senate and House and will require the intensive cooperation of the Legal Affairs Committee during the coming months. Copies of these Public Acts, or Resolution 88, may be obtained from MSMS Headquarters on request.

The Legal Affairs Committee was also instrumental in developing the final form of a new Michigan hospital licensing law, which was passed by both the State Senate and House of Representatives but not sent to the Governor for signature because of a last-minute dispute over provision of funds for hospital inspection. It was erroneously reported in the July, 1967, "Michigan Medicine News Extra" that this bill (SB 16) had passed; it is still eligible for passage in January, 1968, but was a victim of the confusion over funds created by the income tax question. This bill specifically rejects hospital "franchising," and it also provides that there shall be no regulation of the medical or surgical treatment provided a patient by licensed medical personnel. It is expected that SB 16 will be enacted early in 1968 in a form endorsed by MSMS.

Similarly, the Society was highly instrumental in developing and steering through both houses of the Legislature a bill (SB 479) which would have replaced the coroner system in several additional Michigan counties with the medical examiner system. Slight differences between the House and Senate versions of the bill, however, could not be resolved in the final days before the Legislature adjourned because of the time demands of the taxation question. It is expected that SB 479, also, will become law early in 1968.

MSMS had introduced, or strongly supported, several proposals in 1967 which failed to pass but which are still eligible for passage in 1968 and thus are a continuing part of the Society's legislative program. These include bills to license and regulate medical laboratories, to require qualifications for the Directors of Public Health and Mental Health, to create a policy-making Board of Public Health and a policy-making Mental Health Commission, and to repeal the Michigan Basic Science Law.

In regard to the latter, a great deal of work was done by the Legal Affairs Committee during 1967. A repeal bill (SB 229) was passed by the State Senate, favorably considered by a House of Representatives committee and brought to a House vote, then defeated, resurrected and made eligible for a second vote. The House of Representatives, after properly rejecting bills which would have expanded the practices of both optometrists and chiropractors and sending them back to committee for further study, unfortunately assigned SB 229 to the same fate for 1967. It is anticipated that the joint Senate-House committee created by Resolution 88 (above) will also address itself to the repeal of the Basic Science Act.

During early March a bill was introduced which would have provided for the merging of the functions of the State Board of Registration in Medicine, and the Board of Osteopathic Registration and Examination, into a single board. This bill was studied carefully during two meetings of the Legal Affairs Committee and completely analyzed by MSMS Legal Counsel. It was considered concurrently with a massive revision of the Medical Practice Act being prepared by a special committee of the State Board of Registration in Medicine. MSMS was informed that the Legislature itself recognized that the bill which had been introduced was a complicated and controversial one, and that it would not be prepared to consider a possible board merger until 1968, so MSMS was advised to attempt to put the bill into acceptable form prior to that time. As a result, a special ad hoc committee has been appointed to combine the concepts in the legislative bill with the thinking expressed by the Board of Registration, with a view toward attempting to develop a proper vehicle for the 1968 legislative session.

Over twenty proposed bills on various subjects were vigorously opposed by MSMS during 1967 as being ill-conceived and not in the best health interests of the Michigan public, and all were rejected by the Legislature. These also, however, are again eligible for consideration in 1968 and will constitute an additional important part of the on-going legislative program. It can be anticipated that more than 1,000 new proposals will make their appearance in the first eight weeks of 1968 and all will require close scrutiny by the Legal Affairs Committee.

During the 1967 legislative session, fourteen issues of "Medigram" were prepared and sent to approximately five hundred physicians throughout Michigan who had requested to be kept informed of legislative matters on a current basis. This bulletin, which is mailed weekly during the most active legislative period, is available to any MSMS member who requests that he be placed on the mailing list.

Detailed reporting to all MSMS members on the final actions of the Legislature during 1967 is being done through a series of articles in "Michigan Medicine" during the fall months.

Once again, the Committee acknowledges with thanks the vast amount of interest and support given it by MSMS committees and individual members as it has pursued its program since the 1966 meeting of the House of Delegates. Attention is invited to the section of The Council's report to the 1967 House (section on Legal and Governmental Affairs) which explains in some detail the manner in which the several committees of the Society, along with several MSMS staff members, have cooperated in producing a successful effort.

THE REFERENCE COMMITTEE on State and Federal Legislation, James D. Fryfogle, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MATERNAL HEALTH

William W. Jack, MD, *Chairman*

The Committee on Maternal Health is able to report another successful year. Four meetings were held; in September, February, March, and May.

Functional Table of the Committee's Organization and Activities. The work of the Committee in cooperation with the Michigan Department of Public Health, is best outlined, as follows:

ACTIVITIES OF SUBCOMMITTEES

Maternal Mortality

Maternal Mortality Study, 1950 to present
Maternal Mortality Tissue Registry Department of Pathology, U. of M.
Regional Evaluating Conferences
Regional Visiting Obstetricians
Revision of Reporting Forms and Use of Data Processing Equipment
Reports in the Literature

Perinatal Mortality and Morbidity

Michigan Perinatal Mortality Study in cooperation with the Commission on Professional and Hospital Activities
Michigan Perinatal Morbidity Study
Perinatal Newsletter
"Bootie Hill" Exhibit. Shown at state, regional and national meetings

Medical Liaison

Desk Reference Cards
Speakers Bureau on maternal and perinatal subjects for county and regional meetings

Lay Education

Workshops for teachers of Expectant Parent Classes
Regional Working Conferences for Maternity Nurses
Family Life Education

Special

Annual Conferences on Maternal and Perinatal Welfare in cooperation with Clara Elizabeth Fund, Flint
Study on the More Efficient Use of Obstetric Beds in Michigan Hospitals
Physicians' Guide for Family Planning

Maternal Mortality and Perinatal Mortality and Morbidity. The work of the Subcommittee has been previously reported to the House of Delegates, as well as the printed report entitled "Michigan Perinatal Mortality Study." The report has been widely distributed upon request and via the Committee's exhibit "Bootie Hill." An evaluation of this study will be undertaken by the Committee.

In addition, the Subcommittee completely revised the forms used in the Maternal Mortality Study and the new are now being used by the regional visiting obstetricians. Plans are being finalized to use data processing equipment.

The Maternal Tissue Registry Report from January 1, 1966 through December 31, 1966 is as follows:
Total number of cases to date — *486cases.*

Total number received during the above period of time — *46 cases.*

The causes of death are as indicated in the attached list. The leading causes of death in the 46 cases are:

Pulmonary arterial emboli	6
Septic abortions	5
Amnionic fluid emboli	4
Malignant neoplasms	3
Air embolism	2
Postpartum hemorrhage	2
Cause, undetermined	4
	26 cases

It is interesting that vascular causes of death still predominate. Emboli of some form account for 12 of the 46 deaths.

The three cases of malignant neoplasms were: carcinoma of colon, carcinoma of stomach, and malignant melonoma.

The high frequency of deaths of undetermined cause is disturbing.

Material from the Registry has been the subject of three reports during the year. Dr. David Anderson, of the Department of Obstetrics and Gynecology, has presented the material on amnionic fluid emboli at the following meetings: Michigan Society of Obstetrics and Gynecology; American College of Obstetrics and Gynecology; and Central Association of Obstetrics and Gynecology.

Doctor Charles Stevenson's paper on "Sepsis following Caesarean Section" was published in *Obstetrics and Gynecology*.

Medical Liaison. During the past year, the Committee published and distributed the following Desk Reference Cards: Card 9 on "The Management of the RH-Sensitized Patient," Card 10 entitled "Ectopic Pregnancy," Card 11 on "Diabetes and Pregnancy," is being prepared.

Members of the Committee have served as speakers and in an advisory capacity in connection with State Society and county society scientific meetings.

Lay Education. The monumental piece of work done by the Subcommittee on Lay Education was contained in a full report made to and approved by the Committee on Maternal Health at its meeting in March. We have been extremely gratified at the response received following distribution of the report. We feel the program started by the Subcommittee should be expanded so that every school district and/or community in the State, seeking advice and help in setting up a family life education program, should readily receive the encouragement and help needed.

The Committee is grateful to the Clara Elizabeth Fund of Flint for its continued interest and tangible help in cosponsoring the Flint Maternal Health Conference.

Study on the More Efficient Use of Obstetric Beds in Michigan Hospitals. The report of the Subcommittee was presented to and approved by The Council on March 8, 1967. Portions of the report follow:

"*Extent of the problem*: There has been a decline in the total number of births in the State of Michigan since the year 1957, despite an increase in the population of women in the child bearing age; and, further data shows that in the 210 hospitals, licensed for maternity care, there exists surplus obstetrical beds of approximately 557.

"It can be stated that in the State of Michigan as a whole the problem is a relatively minor one. However, where it does exist, it can be real with a rather large economic, as well as operational impact on the community, the administrator and the hospital staffs involved.

"*Guideline Recommendations:* Since the State as a whole is not faced with a massive problem, we think that it speaks well for the present policy of the Michigan State Department of Public Health which has been advocating 1) swing units; and 2) consolidation of obstetrical services in one hospital in a service area. We feel that this policy should continue.

"*Recommendations for Changes in the Rules and Minimum Standards:* The Committee and the advisors visited two hospitals exhibiting a surplus of obstetrical beds and made the following determinations:

"1) The formula for establishing the fact that an obstetrical bed was surplus is quite accurate.

"2) We recommend that the Rules and Minimum Standards be so changed or amended to permit the utilization of maternity beds for a) Any patient who is pregnant, regardless of duration of gestation and including threatened abortions, incomplete abortions, and ectopic pregnancies, etc.; b) Post-partum patients during the hospitalization immediately following delivery.

"3) We recommend that the Rules and Minimum Standards for Hospitals be amended to permit the utilization of maternity beds for clean gynecological cases, with the following restrictions:

"(a) Hospitals which had 500 or more deliveries in the preceding calendar year would be eligible to apply for individual consideration in regard to utilizing maternity beds for clean gynecological cases.

"(b) Hospitals applying for individual consideration would be evaluated by the Michigan Department of Public Health to determine the hospital's surplus bed capacity according to a specified formula. (Surplus beds will be those over and above the bed requirement for obstetrical admissions.)

"(c) When it is determined that the Department has six or more surplus obstetrical beds, the hospital staff, with the approval of the hospital board of trustees, would develop a plan whereby these surplus beds could be utilized in a safe manner for the care of clean gynecological cases. It would be expected that the plan submitted would meet the requirements of Bulletin #38 of the J.C.A.H. However, the authority granting privileges would not be limited to the minimal J.C.A.H. restrictions. Specific exclusion of the following type of gynecological cases would be mandatory: 1) Active infection — either acute or chronic; 2) frank malignancy other than carcinoma in situ; 3) patients admitted for radiotherapy; 4) any gynecological patient who is on any other service in the hospital including the gynecological service may not be transferred to the maternity unit.

"4) The Maternal Health Committee would offer to assist the Michigan Department of Public Health through the establishment of a standing subcommittee which would participate in the evaluation of plans submitted by individual hospitals and also, assist in providing consultaton to those hospitals in the development of an acceptable plan.

"5) Acceptable plans would receive approval for one year. Reapplication for approval would be necessary for extension of the approved plan or for modification of the approved plan.

"6) The Maternal Health Committee through this same standing subcommittee would offer to assist the Michigan Department of Public Health in the continuing evaluation of this program in individual hospitals."

The Committee's report has been transmitted to the Michigan Department of Public Health.

Physician's Guide for Family Planning. With the cooperation of the Michigan Department of Public Health, the "Physician's Guide for Family Planning" was printed and distributed to all MSMS members.

Legislation. The Committee studied all legislation concerned with the care of the mother and her child and made recommendations concerning proposed sterilization and abortion laws and the teaching of physical education in schools.

Michigan Plan for the Identification of the High-Risk Mother. A. C. Rutzen, MD, a member of the Committee, is conducting a study to try to ascertain how to identify the high-risk pregnant patient. A preliminary report was presented to the Committee in May and the study will be continued.

Infant Mortality in the United States. The Committee briefly discussed statistics on infant mortality for the United States as compared with that of six Western European countries. The problem of infant mortality and morbidity, especially in the "health-depressed" groups of our state and nation, will be studied by the Committee.

The Chairman wished to express his deep appreciation to the members of the Committee, the consultants and honorary members for their unfailing support and enthusiasm. He also is grateful to the MSMS staff, especially Miss Helen Schulte, for wholehearted assistance through the year.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The Reference Committee was impressed with the great and continued efforts of this Committee in its attempts at reducing maternal and neonatal morbidity and mortality in this State. The Reference Committee further encourages continuation of these fine efforts. The Committee on Maternal Health deserves high commendations for these services. It is recommended that its report be accepted."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON MEDICAL SOCIO-ECONOMICS

DALE L. KESSLER, MD, *Chairman*

The Committee on Medical Socio-Economics' long range planning project (position papers) is progressing nicely. Several papers from experts involved in shaping the environment that will surround the future practice of private medicine have been submitted to the Committee. (Two of these papers, "The Future of Health Insurance, Prepayment and Medicine — A View of 1985" by Charles P. Hall, Jr., Ph.D. and "The Outlook for Group Practice-Prepayment Direct Service Plans During the Next 20 Years" by Caldwell B. Esselstyn, MD, have been published in *Michigan Medicine.*)

Additional papers to complete the project are now being contracted. These will include the following subjects:

(1) The Influence of Labor on the Future Practice of Medicine

(2) The Influence of Medical Education on the Future Practice of Medicine

(3) The Influence of the General Economy and its Socio-Economic Environment on the Future Practice of Medicine

(4) The Influence of Para-Medical Personnel on the Future Practice of Medicine

(5) The Influence of Management on the Future Practice of Medicine

An analysis of the long range predictions of the authors will give the medical profession a unique opportunity to develop programs that will meet the future health care needs and demands of the American public. To this end, members of the Committee are inviting physicians from their respective areas to react to the challenges presented in selected papers and to develop suggested courses of action for MSMS. Also, medical socio-economic committees of component societies have been invited to review the papers and to forward their suggestions to this Committee.

Workshops will be conducted in selected parts of the state to gather additional opinions from the grass-roots level of MSMS members.

After all papers have been submitted, they will be published in one volume. A volume will be sent to each state medical society for study. It is hoped that this action will result in new approaches and programs being adopted by other state medical societies to meet the future challenges that medicine will face.

This activity will lead, it is hoped, to new programs on a state and national level.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"Our Reference Committee wishes to encourage this Committee in the continuance of their publications and their analysis of programs involving their area of activity. We commend their work to date and wish to approve their report."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICINE AND OSTEOPATHY

JOHN J. COURY, MD, *Chairman*

Report on Osteopathy in the United States and Michigan.

The Committee is studying the "Report on Osteopathy in the United States and Michigan" as prepared by the Citizen's Committee on Education for Health Care. This report covers such topics as Distribution of Osteopaths in the United States and Michigan, Osteopathic Education, Osteopathic Hospitals and Contributions of Osteopaths to Health Care in the United States and in Michigan.

Developments regarding Single Medical Practice Act.

The Committee is consulting with MSMS Legal Counsel in the development of a bill to establish a single medical practice act in accordance with the wishes of the House of Delegates. The matter of a single medical practice act will be under study by the House State Affairs Committee between June and December, 1967 and no doubt MSMS will be called to present testimony. To this end the Committee has under development a white paper which will contain a comprehensive positive program to resolve the MD-DO problems in Michigan.

PCHA Problem. The Committee has consulted with the director of the Peoples Community Hospital Authority in Wayne County and has offered its advice and guidance in resolving problems that have arisen regarding the relationships between doctors of medicine and doctors of osteopathy at the Seaway Hospital.

The chairman and members of the Committee have met with county medical societies to discuss both state and local problems regarding MD-DO relationships.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"This Committee has continued its excellent work and should be encouraged to continue its efforts especially along the development of the 'white paper'. This should greatly aid in the resolution of many MD-DO problems."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON MENTAL HEALTH

BENJAMIN JEFFRIES, MD, *Chairman*

The Committee had the privilege of participating informally in preparation for the Annual Meeting of the American Psychiatric Association held in Detroit in May, 1967.

The Chairman appointed a subcommittee to review and prepare a report of preliminary legislative bills to change the system of payment for patients receiving care from various hospitals and clinics of the Michigan Department of Mental Health. Reasons for this study were: 1) The rapid development of third party payment for services rendered; 2) The subsidy by the Department had expanded so rapidly that finances were a considerable drain; 3) Lowered costs to hospitals and clinics of the Department; 4) Expansion of such services through Community Mental Health Acts.

The Committee made the following recommendations, which The Council referred to another Committee for eview and report. The Council will take action on the ecommendations when the review report is received.

1. It is recommended that the Department of Mental Health move towards a cost for service basis, recognizing of course that the State services would be available for all categories of patients who could not pay the entire or any of the cost for service.

2. In order to develop a cost for service basis, each hospital and clinic should develop a realistic cost accounting system as the costs from one institution to another will show considerable variation. Also this cost accounting system should be developed on the basis of the type of service rendered, i.e., acute service, geriatric service, chronic care service, infirmary, adult, adolescent, children's services, etc.

   It is also recommended that the cost for education of trainees, that is, resident physicians in psychiatry except as they contribute to service, and trainees in other related disciplines, as well as the costs of research, should be borne by the State, and not included in the cost for service basis; also the cost of "mental health education" carried out by members of the Department of Mental Health be excluded.

   Further, it is recommended that costs for hospitalization, and the cost for physicians' care, be separated in the accounting system.

3. All hospital and clinic units should attempt to clarify with Blue Cross and Blue Shield whether they are participating or nonparticipating units.

4. There are several models of reimbursement of costs within the medical profession:
   a.) One model, illustrated by Ford Hospital or University Hospital at the University of Michigan, where both the hospital and medical costs are collected by the hospital and all staff are on salaries.
   b.) A second method is illustrated by the Detroit General Hospital, and the Wayne County General Hospital, where the hospital costs revert to the hospital but the medical costs revert to a separate research fund.
   c.) The third method is exemplified by private hospitals where the hospital costs revert to the hospital, and the medical costs revert to the physician.

   The Subcommittee recommends that consideration be given to item "b" above; that the hospital costs revert back to the general fund of the legislature. However, the committee strongly urges that a separate accounting of these collected funds be maintained so that the legislators will be aware of the hospital costs generated by the units of the Department of Mental Health.

   It is also recommended that the physicians' charges, which would be on a cost basis, be placed in a separate fund to support research in the various institutions and clinics of the Department.

The Committee considered a letter which stated "that a certified psychologist under the Michigan Psychologist Registration Act is allowed to practice on his own in an agency, but, if he is in a private psychiatric clinic, he is not allowed to work under the direct supervision of a psychiatrist but must at that level be under the supervision of a certified consulting psychologist. The Committee feels there is need for clarification on amending cerification laws dealing with psychologists. The Council requested a study of the need for amending the Psychologist Certification Law.

The Committee considered passage by Congress of a drug dependency and rehabilitation bill dealing with civil commitments; alcoholism, legal and criminal responsibility of an alcoholic; and the Community Health Facilities and Centers Act.

A report of a study subcommittee on hypnosis was given and the Committee received a request from the MSMS Legal Affairs Committee for an opinion on proposed legislation that provides "That only licensed physicians and dentists should be permitted to use hypnosis." This proposed legislation is patterned after the New York Law, the contents of which the Committee concurs in, and also feels that there is a need for establishment of standardized training centers, but that it would be a long term project.

The Subcommittee on Lay Education of the Committee on Maternal Health expressed the necessity to coordinate the efforts of other agencies to bring them into concert and rapport on the subject of the Family Life Education Program, and requested the appointment of a member of this Committee to serve as liaison. J. J. Llinas, MD, was appointed.

A report concerning the attendance of the Chairman and the staff assistant at the Thirteenth Annual Conference of Mental Health Representatives of State Medical Societies in Chicago was distributed. The theme of this Conference was "The Team Approach."

The Committee considered 1966 MSMS House of Delegates Resolution 66 re Alcoholism as a Disease Entity. The House of Delegates in September, 1966, referred it to this Committee for an opinion.

Resolution 66:

> Whereas, in 1956 the American Medical Association House of Delegates unanimously passed a resolution declaring alcoholism to be a disease and urged that it be treated as such in general hospitals, and
>
> Whereas, more and more courts across the country recognize this principle, and
>
> Whereas, general hospitals presently are reluctant to admit an alcoholic patient and consequently, the physician is forced to resort to subterfuge in order to gain patient admission under assorted diagnoses of gastroenteritis, syncope, organic brain syndrome, and so forth, and
>
> Whereas, the federal government recently recognized the diagnosis of alcoholism per se as an admission diagnosis in veterans' hospitals, therefore be it
>
> RESOLVED: That the Michigan State Medical Society House of Delegates approve the recognition of alcoholism as a disease entity, and be it further
>
> RESOLVED: That Michigan Medical Service recognize alcoholism in the fee schedule.

In response to a Committee letter, Blue Shield stated: 1.) That MMS does not exclude treatment of alcoholism in any of its contracts; 2.) Does routinely pay for such care in any accredited institution where other benefits are provided; 3.) Is probably paying for this care in general hospitals, although will not pay for care in an "alcoholic" institution; 4.) That the sense of the old AMA resolution and Resolution 66 seems to be that alcoholism should be accepted for care in general hospitals; 5.) It would appear that Blue Shield's current policy is in complete agreement with these resolves.

It is the Committee's opinion that MMS should recognize alcoholism as a disease entity and that its current policy should continue.

The Council did not adopt the Committee's recommendation of approval but instead recommended that it be transmitted directly to the 1967 House of Delegates in this report.

The Committee invited Mr. Ralph Daniel, Chief, Alcoholism Program with the Department of Public Health and Harold H. Gay, MD, with the Michigan State Board of Alcoholism to attend the Committee's deliberations and to discuss and answer questions regarding the current progress of educational and preventive programs for the discovery, treatment and rehabilitation of alcoholics in Michigan. Items discussed after review of the proposed Alcoholism Bill prepared by the Michigan Department of Public Health were: 1.) Creation of an alcoholism program within the Department; 2.) Questions re whether or not an increase in earmarked funds would be adequate to properly implement a program of this nature; 3.) The problem of educating and counseling; 4.) Admissions to general hospitals; 5.) The need for collaboration between the Michigan Departments of Mental Health and Public Health; 6.) Awareness that alcoholism is a continuing responsibility of the psychiatrist.

The consensus was that there was an urgent need for detoxification and diagnosis centers. The Committee adopted the following principle:

> The Committee acknowledges that alcoholism is a medical, as well as a mental health problem, and, recognizing the responsibility that the medical profession has in this field, favors a program which will be adequately structured, have professional planning methods and the availability of sufficient funds with which to properly accomplish the purpose of this program.

Two members of this Committee, who are also members of the MSMS Alcoholism and Drug Addiction Committee, were instructed to convey this Principle to that Committee.

The A.I.D. Bulletin, which is a mimeographed publication of MSMS, is distributed to both non-psychiatric physicians and lay leaders as a primary source for factual professional information. The Committee has noted a fine response from those receiving this Bulletin and is planning another issue which will include a compilation of newly enacted laws dealing with mental health and mental retardation, as well as other informative material.

The members of this Committee have devoted their time and effort to the many complex problems in the area of mental health and mental retardation and I should like to take this opportunity to laud them for this devotion.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"Our Reference Committee felt that this excellent report should be accepted with commendation. We especially noted that the Committee considers alcoholism a medical as well as a mental health problem, and feel that the medical profession should recognize its responsibility in this field. The programs for the care of the people with this condition, as outlined in this report, are admirable."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON OCCUPATIONAL HEALTH

William Jend, Jr., MD, *Chairman*

One of the most important concerns of this Committee has been improvement in the medical aspects of Workmen's Compensation administration. Specific recommendations endorsed by the Committee on Occupational Health in 1963 and subsequently endorsed by The Council were introduced as legislation for the first time in the 1966-67 session. While these amendments to the Workmen's Compensation law did not get out of committee during this session, this Committee is anxious to obtain the full support of MSMS and other interested health groups in bringing about enactment of this legislation in the next session. A major portion of the time of the Committee and its members has been and will be directed to this end. The Chairman discussed this legislation before the MSMS Legal Affairs Committee.

Many health screening programs are conducted in the industrial setting and this Committee is very concerned with proper safeguards and guidelines for conducting such programs. This Committee reviewed such guidelines prepared by the Wayne County Medical Society and will review with interest a similar report being prepared by an ad hoc committee of MSMS.

The Committee is concerned about being of service to other MSMS members who may be doing either part-time or occasional work in occupational medicine as well as occupational health committeees in the various county societies. To that end, the Committee is studying the activities of the various county societies in occupational health and means of making its advice and counsel available where it can be of service. As a means of focusing attention on occupational medicine in Michigan, the Committee also hopes that a future session of the AMA Congress on Occupational Health will be scheduled for Michigan.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The Reference Committee recommends acceptance of this report, with commendation to its members for the fine work they are doing."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

Harry A. Towsley, MD, *Chairman*

The Committee on Postgraduate Medical Education is pleased to report that 33 programs were provided to 20 selected Centers throughout the state this year, and that 770 physicians registered for these programs. Approximately 75% attended both Fall and Spring programs; or 50.7% total number of physicians (1332) residing in the geographic area where the 20 Centers are located.

It is also noteworthy that 57 faculty members from Wayne State University School of Medicine and the University of Michigan School of Medicine traveled by air or by car 25,300 miles over the state to provide these programs.

Estimating time of travel and meeting time to make these courses possible at the home base of those physicians who attended, approximately 1208 hour-days of faculty member time were required to provide this service. This estimate does not take into account the time needed by each faculty member to prepare for his presentation at each Center.

The Committee is deeply indebted to those faculty members who made these programs successful and meaningful for the members of MSMS.

This year the Committee attempted to have each Center consider the establishment of a clinical conference program with presentation of patients, in addition to the usual didactic discussion. In those centers where clinics were arranged this year, both audience participation and responses from the visiting faculty indicate that there is far better "give and take" and better opportunities to ask and answer questions than with the lecture type of program. The clinic offers a broader opportunity for continuing education infringing into the area of all of the specialties of medicine rather than one chosen subject which may appeal to only a small segment of physicians practicing in the community. The Committee would like to encourage broader use of the Clinical Conference type of presentation.

At its two regularly scheduled meetings during the year, the Committee gave serious consideration to the following:

1) Development, if possible, of a mechanism for evaluation and measure of effectiveness of these programs in improving and updating the physician's knowledge and thus broadening his scope of activities in providing medical care. For this purpose a subcommittee was appointed and will report at a later date.
2) The Committee's role in relationship to the Heart Disease, Cancer, Stroke, and Related Disease program and what it might do to further education to physicians through the regional programs. A subcommittee was appointed to explore methods of cooperation with the Michigan Association for Regional Medical Programs, Inc.
3) The possibility of utilizing radio, television, telephonic communication and other electronic devices that might be used to provide continuing education for the physicians within the State. An active sub-

committee is studying these aspects of communication.

4) Inasmuch as the next three Annual Sessions of MSMS will be held in Detroit, the Committee is considering the possibility of providing a series of one day or at least a full half-day program in Centers easily accessible throughout the northern part of the Lower Peninsula and across the Upper Peninsula. It is anticipated that such programs would bring far greater educational opportunities into the regional areas, thus making it possible for physicians to procure continuing educational opportunities at the local level.

The Committee expresses its deep appreciation and thanks to the Councilors and in particular to those physicians responsible for organizing and arranging their programs for their local communities. Without their help and cooperation, it would be impossible for MSMS to carry out the function of continuing education at the community level.

During this current year the Committee, and I am sure every physician in the State of Michigan, has been saddened by the loss of two long-time Chairmen of the Postgraduate Medical Education Committee of the State Medical Society, Dr. John McFarland Sheldon and Dr. Howard H. Cummings. These two men were indefatigable workers and had a deep concern for the need of providing continuing medical education to the practicing physician once he had completed his medical school education. Their wise counsel, advice, and help will be sorely missed by this Committee.

The Chairman of the Committee extends his deep appreciation to the other members of the Committee for their thoughtful assistance in helping to arrange useful programs for the various centers. In particular, the Committee owes a debt of gratitude to Herb Auer for his aid in publicizing these programs and his service as Secretary for Committee meetings.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"Our Reference Committee considered this an excellent report, and moves to accept it with gratitude and respect for the great work which the Committee has done in this field. Our Reference Committee recognizes the importance of continuing education at all levels, and feels that our State is very fortunate in having the continuing effort of this dedicated Committee."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON PROFESSIONAL INSURANCE PLANS

FREDRICK WEISSMAN, MD, *Chairman*

Status Report of MSMS Group Insurance Programs

Group Disability: This plan is the oldest and the one which has attracted the greatest participation. Significant improvements have been made in coverage since this plan was initiated in 1953. Higher amounts of indemnity and an alternate longer benefit period have been made available. A guaranteed renewable feature, unique in the industry, was added during the past year.

Number Insured:	1,933
Premium Volume:	$266,771

Group Life: Although the problem of participation is more difficult in this area because of the legal limit of $10,000, the premium volume has increased considerably for this plan. Conversions from term to permanent insurance have assisted in increasing the premiums paid.

Number Insured:	1,237
Premium Volume:	$204,144

Family Plan: This plan was developed and offered to augment the Group Life Program primarily because of the $10,000 limit imposed by state law on the original contract. Amounts up to $30,000 are available and dependents may be included with an amount of $5,000 for each member.

Number Insured:	541
Premium Volume:	$141,236

Overhead Expense: This is one of the newest plans. As more members become aware of the need for this coverage, it is believed participation will improve. The carrier has recently authorized an increase in the monthly indemnity from a maximum of $1,500 to $2,000.

Number Insured:	259
Premium Volume:	$40,531

High Level Accident: This is also one of the newer plans. It was designed to provide a popular type of insurance at exceptionally low cost. Here again it is believed participation will increase as members become aware of the price advantage offered over individual plans.

Number Insured:	456
Premium Volume:	$32,546

Development of New Programs

The Committee has felt that there is a real need for new programs that will enable the physician to compete more effectively with industry in the hiring of medical assistants and other employees.

We have therefore developed and submitted to The Council for approval, the following two programs: 1.) Accident and sickness plan for employees of MSMS members; and 2.) Term life plan for employees of MSMS members.

Also, the Committee has under study the following two programs and will make its recommendations to The Council just as soon as its work is completed: 1) Hospital indemnity plan for MSMS members; and 2) One-year elimination disability plan for MSMS members.

The Committee will continue its efforts to keep abreast of the many changes in insurance so that appropriate steps can be taken to insure that all MSMS insurance programs are the best available.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"Our Reference Committee moves to accept this report with commendation. We believe that our doctors should review the policies that are available to them, their families and their employees through MSMS insurance plans. The recent brochure distributed on this subject might be repeated in another six months."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PUBLIC HEALTH

O. D. STRYKER, MD, *Chairman*

The Committee on Public Health held one meeting on April 12, 1967.

Public Health and Medical School Curricula. Last year, the Committee requested the Committee on Legal Affairs to help assure that the matter of financial assistance to the two Michigan medical schools to carry out their proposed public health and preventive medicine programs be given priority by the Michigan Legislature. Subsequently, the Committee was informed by the Committee on Legal Affairs that "since Wayne State University and the University of Michigan themselves have control over the expenditure of money appropriated to them by the Legislature, the approach cannot be implemented as written. The only thing that can be done is to generally encourage an increase in the overall appropriations so that the schools themselves will have more dollars to do the job. The Committee on Legal Affairs is continually urging expansions of medical education facilities in many ways, and it knows that both Universities are interested in continual improvement in their preventive medicine and public health programs."

The Committee heard a report from A.D. Hunt, MD, Dean, College of Human Medicine, Michigan State University, on its present and proposed programs in preventive medicine and public health.

The Council has approved the recommendation of the Committee that Michigan's medical schools be encouraged to include in their curriculum the teaching of public health and preventive medicine.

Liaison with Radiation Section of the Michigan Department of Public Health. The Committee reviewed the regulations governing the use of radioactive isotopes, x-radiation, and all other forms of ionizing radiation.

The following recommendation of the Committee has been approved by The Council: "That the Committee on Public Health and Preventive Medicine be the MSMS liaison with the Radiation Section of the Michigan Department of Public Health and that the MSMS President appoint two physicians knowledgeable in the field of nuclear medicine as advisors to the Committee on Public Health and Preventive Medicine."

Measles Immunization. The Committee is assured that the progress being made in the State of Michigan in regard to measles immunization is very satisfactory, but it wished to stress the importance that this good work continue.

The Committee expresses its thanks and appreciation to the Michigan Legislature for its appropriation of funds to purchase the measles vaccine. In addition, the Committee extends its commendation to Michigan's component societies which have participated in the measles immunization program and urges all societies who have not as yet participated in such programs, to do so.

Screening. The Committee has published in *Michigan Medicine* a short explanation of the law concerned with tuberculosis testing and a review of the rules and regulations as adopted by the Michigan Department of Public Health. The Committee wished all physicians to know that the law was signed two years ago and that the rules and regulations, as set up by the Michigan Department of Public Health, are now part of the Administrative Code and are in effect.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"Our Reference Committee wishes to commend the activities of this Committee, especially its work on the measles immunization program. We also commend the county medical societies for their participation in this effort."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON PUBLIC RELATIONS

Brock E. Brush, MD, *Chairman*

Every day every member of MSMS is responsible for the success or failure of the MSMS public relations efforts.

While every member may not realize it, he is unofficially a member of the MSMS Committee on Public Relations. Every day, every doctor must help solve our complex problems . . . some people are not convinced that health care is available day and night . . . some occasionally may have to wait in a doctor's office . . . some do not believe physicians are interested in the elderly . . . some wish they had closer patient-physician relationships . . . etc.

The projects of the Public Relations Committee are developed and refined from the resolutions adopted by the House of Delegates, from action motions of The Council, from recommendations of the many MSMS committees and from ideas expressed by members.

Ideally every MSMS member should accept the challenge, opportunity and responsibility to serve on the big, every-member Public Relations task force and submit ideas and volunteer for various assignments.

The Report of The Council, Part I, beginning on Page 8, includes brief references to many MSMS public relations, educational projects. All of the items there and some others listed below are generally part of the work of the Public Relations Committee. The Committee seeks to outline programs in broad general guidelines for the staff to implement by working with MSMS officers, committees, delegates, members, auxiliary members, medical assistants, the news media, schools, etc.

The following activities are not in any special order of importance.

Health Careers Mobile: Dedicated at the 1965 MSMS Centennial Session, the mobile unit visited many communities during 1965-1966 to tell school children and adults about the exciting Michigan developments in medical research and health care. The handsome, impressive unit was transferred in the fall of 1966 to the Michigan Health Council and many exhibits were changed and new ones added to emphasize careers. MSMS contributed to the financing this past year, and MSMS staff assisted in the scheduling, manning, transporting, etc. A complete calendar of the communities visited, etc., is available from the Michigan Health Council, rather than print it here. Every week, the mobile unit moved from one community to another to tie in with county fairs, local health career recruitment efforts, etc. The response from students, teachers, counselors, school administrators, hospital officials, nursing leaders, etc., was most enthusiastic. Many young boys and girls — and adults too — have been encouraged and inspired to consider careers in medicine and the health fields.

Career Booklets: The supply of AMA career handbooks, *Opportunities Unlimited,* was exhausted during 1966-67. During 1965-66, MSMS ordered 10,000 copies of the booklet and printed a special eight-page yellow insert to tell the readers about 51 health careers offered by 115 Michigan colleges, hospitals and institutions. Distribution was made by MSMS to school counselors, to school and public libraries, to interested physicians, and to others who advise parents and students about higher education and careers. Additional copies of the booklet will be purchased soon, it is hoped, when the AMA reprints the pocketsize book.

Education Thrusts: The PR Committee co-operated this past year with several MSMS scientific committees to conduct ambitious promotional efforts on several selected matters. Special projects were added to the usual on-going PR efforts with the mass media to give MSMS more visibility with positive thrusts. During last August and September, MSMS sought to identify the doctor of medicine with high school football in a Medicine-Sports campaign. MSMS stressed the MD concern for better VD control during October and November. The next push, Alcoholism Education in December and January, sought to convince both the doctors and public that "alcoholism is treatable." The Family Life Education project in the spring is detailed in the Maternal Health Committee report. The two-month efforts were rated "very promising" as a positive way to tell the Michigan citizen that the physician and medical society are concerned about his health. The Committee has started 1967-68 plans in such areas as Quackery, Smoking, Goiter Prevention, etc.

TV News Clips: Among the several new MSMS efforts to inform the public was one to provide TV stations with short films of MSMS officials being interviewed on current medical topics. A commercial firm produced the 16 mm sound film clips at the MSMS headquarters for distribution to every Michigan TV station. Follow up surveys with the TV news directors and station managers indicated a high degree of reception. The TV news clips were handled to merit prime time during the daily TV news programs — and not sent out as public service spots. No other association or organization in Michigan has tried this new technique as yet. MSMS officers performed well, handling answers in a positive manner to questions about medical manpower needs, nursing home shortages, venereal disease control, crime prevention, and other topics in the news.

MSMS Radio Tape Series: For quite a number of years, MSMS has provided 15-minute and 5-minute tapes to about 40 Michigan and midwest radio stations. While this is a project of the MSMS Committee on Scientific Radio, the PR Committee did suggest subjects and physician—speakers from time to time to tie in with MSMS public relations campaigns. The programs this past year again sought to increase the knowledge of the public about medical matters and good health practices.

Newspapers: Almost every week, MSMS provided news material to Michigan newspapers; and from time to time to Michigan and national magazines, and to radio and television stations.

News releases were well received by both weekly and daily papers. Quite often the MSMS releases resulted in editorial comment in a positive direction for the medical profession.

Throughout the year, special efforts were made to work with the 20 Michigan reporters who are science writers. Three are veteran reporters while 17 are "trainees" in the American Society of Science Writers program.

The 1967 Annual Conference on Medical News Reporting: The conference was held at Ann Arbor with excellent cooperation from the University of Michigan Medical School. About 50 editors, newspaper reporters, free-lance writers, journalism professors, health agency publicists, physicians and students participated. U-M Dean William N. Hubbard, Jr., M.D., luncheon speaker, discussed the need for more doctors of medicine in Michigan. Plans have been started to hold the 1968 meeting at Wayne State University. The 1966 conference was at Michigan State University.

MAP Formula Television Programs: Although produced by the Michigan Association of the Professions, this weekly series over WJIM-TV, Lansing, each Tuesday night, was the major ongoing television effort of MSMS. Often the programs dealt with health matters and featured physicians. MSMS Executive Director Brenneman acted as host for the third consecutive year. An estimated 250,000 viewed the educational program each week.

Guest Spots on Radio and TV: MSMS increased its efforts this past year to offer physicians to appear on the many radio and television personality programs, especially in the Detroit area. MSMS officers, committee chairmen and members have been interviewed about interesting unique MSMS projects and medical advances.

1966 Community Health Week: MSMS cooperated again with the AMA-sponsored Community Health Week project and encouraged and counseled county societies to join the fall effort. Major emphasis was on health manpower needs. The statewide effort was co-sponsored with the Michigan Association of the Professions and the Michigan Health Council.

Interprofessional Liaison: Better understanding was the goal this year in the many MSMS liaison relationships. Liaison committees functioned well with several other professional societies. Once again, physicians played key roles in the Michigan Association of the Professions, which was founded by MSMS. The MAP Congress of the Professions, the MAP Legislative Committee work, the MAP television program, et al, deepened the channels of communication and cooperation this year.

The Michigan Health Council continued its effective work in Career Recruitment, Public Relations, Placement Services, etc. The MHC was a strong ally in telling the need for more doctors and health team members.

MSMS was proud too of its efforts to help the recently-established Michigan Council on Smoking and Health. MSMS is one of the active sponsoring member organizations. The Smoking and Health Council has ambitious 1967-68 plans to work with and through the Michigan PTA and Michigan Youth Council. The PR Committee has plans to actively cooperate.

Liaison with Woman's Auxiliary and the Medical Assistants: The Auxiliaries were valuable associates in the MD efforts in careers, and many wives helped "man" the Careers Mobile. The Medical Assistants have worked to improve physician-patient relationships. Both groups also helped with legislative work.

Representation at Conventions and Conferences: To supplement MSMS PR efforts through the mass media, MSMS reached thousands of people this past year by providing speakers and resource experts at many Michigan conventions and educational conferences. Invitations were carefully studied and preparations were thorough. Speakers and official MSMS representatives supplemented exhibits and the distribution of materials.

1967 MSMS Conferences: The former County Secretaries-Public Relations Seminars have been broadened in subject matter to cover legislative and governmental relationships. The 1967 Conference did offer some PR guidance and PR opportunities and problems were discussed at each of the preceding regional workshops across the state.

1967 AMA Communications Institute: The Public Relations Committee Chairman led one of the workshops and about 15 MSMS members and staff representatives participated. Throughout the year, MSMS projects were reported in the weekly *AMA News* and the *PR Doctor* magazine.

Medilabels: Thousands of MSMS Medilabels for driver's licenses were distributed again this past year to MSMS members and thus on to patients. Almost 100,000 Medilabels have been mailed out by MSMS in two years. The Council in July directed that another promotion push be given this project this coming year.

Distribution of MSMS Century of Service in Medicine: This excellent MSMS history by William G. Stapleton, Jr., M.D., MSMS Historian, was sent to college libraries, Michigan daily newspaper editors, *Michigan Medicine* advertisers, and other selected groups for its public relations value. Generous letters of appreciation have been received by MSMS.

Distribution of Pamphlets: The PR Committee sought to distribute excellent brochures, pamphlets, booklets, etc., of the AMA, Michigan Health Council, AMPAC and other related organizations to both the public and the professions. Many printed pieces were distributed through such concerned organizations as the PTA, Child Study Clubs, Boy Scouts, Farm Bureau Women, and others. A new technique was started to bring new authentic materials to the attention of physicians with a coupon now in each issue of the mid-month blue news-extra edition of *Michigan Medicine.* The coupon approach has worked well.

Distribution of Motion Pictures: MSMS filled numerous requests for films about careers, diseases and related material matters for school assemblies, service club meetings, convention programs, church discussion groups, etc.

In closing this report, the Chairman wants to recognize the excellent working relationship between the MSMS staff and the PR Committee. The staff continues to suggest workable, unique programs to meet our public relations needs. The staff then takes the broad guidelines approved by the Committee and The Council and carries them out with imagination and dedication.

The Committee welcomes ideas from component societies and individual members as it conscientiously seeks to fill its responsibilities.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"Our Reference Committee reviewed the work of this Committee during the past year and wishes to compliment the Committee on its various efforts, particularly the Health Careers Mobile, the Career Booklets and other educational thrusts. We commend the effort put into the 1967 Annual Conference on Medical News Reporting and Community Health Week. The liaison work was especially commendable, as was the distribution of selected motion pictures to service clubs, etc. We recommend acceptance of this report,

and especially compliment the staff of MSMS for their continuing excellent work."

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON RESPIRATORY DISEASES

R. A. RASMUSSEN, MD, *Chairman*

Cigarette Smoking. The Committee again discussed the need for education of physicians and all persons, with special emphasis to young persons, of the health hazards of cigarette smoking. An article on this subject is being written and will be published in *Michigan Medicine.* In addition, the Committee is recommending to all hospitals in Michigan that they discontinue the sale of cigarettes within the hospital. The Committee feels this stand would clearly indicate the medical profession's general stand on cigarette smoking.

The Committee will again distribute pamphlets and other information on smoking and cancer and other respiratory diseases in one of the scientific booths at the 1967 Annual Session in Grand Rapids.

Tuberculosis. The Committee reviewed the Rules and Regulations for the Control of Tuberculosis, which are now in effect, as developed by the Michigan Department of Public Health. Since the information contained in the Rules and Regulations will be helpful to physicians in making school examinations, it has been recommended by the Committee that this information be printed in *Michigan Medicine.*

At its meeting in the autumn, the Committee will meet with the representatives of the Michigan Tuberculosis and Respiratory Disease Association.

Air Pollution. The Committee reaffirmed its June 8, 1966 Statement on Air Pollution, as follows:

"The Michigan State Medical Society, through its Committee on Respiratory Diseases, officially endorses the principle of reasonable and scientific study directed toward the sensible control of the major problems of air pollution, whether this be the dusts or wastes of industry, the products of combustion of gasoline or oil (automobiles) or the combustion products of home heating and burning equipment, or of smoking tobacco. All of these may have potential effect on man via the respiratory system and are, therefore, of concern to the physician, especially as they are known to affect health adversely."

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, "approved the adoption of this report with commendation, and noted the Committee's continuing work in the fields of cigarette smoking and air pollution."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RURAL MEDICAL SERVICE

ROBERT E. RICE, MD, *Chairman*

The Committee had liaison and discussions with members of several other organizations interested in health career recruitment. Guests included:

Mrs. Edward Lake, Health Careers Chairman, Woman's Auxiliary to MSMS; Mrs. Lottie Waterman, Health Careers Coordinator, Michigan Department of Education; Miss Rosalyn M. Glysels, RN, Director, Division of Practical Nurses, Grand Rapids Junior College; Charles Downs, Michigan State University; George Andrews, RPT, Chairman, Division of Therapy, Rehabilitation Institute, Detroit, Michigan; Mrs. Joyce Randall, RN, Director of Nurses, Lansing Community College; Robert Johnson, RPH, Executive Director, Michigan Pharmaceutical Association; Fred Towne, PR Director, Michigan Hospital Association, and John A. Doherty, Executive Director, Michigan Health Council.

Mr. Doherty gave a comprehensive report on the MD Placement Program in Michigan. Each gave a report of career activity.

Dr. W. G. Birch, a member of the MSMS House of Delegates and of the Education Liaison Committee on Medical and Paramedical Education, outlined implementation of Resolution 20 (re: Physicians' Assistants). Doctor Birch also discussed need for general practitioners and urged cooperation with the Subcommittee on General Practice, and its Chairman, J. B. Rowe, MD, Flint.

The Chairman of the Rural Medical Service Committee has been invited to attend meetings of the above committee and, to avoid duplication of effort, our committee will let the Subcommittee on General Practice spearhead this effort.

R. T. Wills, MSMS staff, reported on the Health Careers Mobile exhibit changes and the plans of the Michigan Health Council for its continued use in recruitment of health personnel.

Doctor Rice reported on suggested changes to improve Community Health Week.

Doctor Rice reported on emergency care in rural areas and urged that ambulance drivers and helpers be given training in first aid, such as offered by the American Red Cross, and that physicians make themselves available for training and consultation. A resolution on this subject was unanimously approved.

Doctor Rice expressed thanks for the Committee's cooperation in the diverse activities of rural medical service.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, approved this report, commending the Committee especially on its work in health career recruitment.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON SCIENTIFIC RADIO AND TELEVISION

JOHN R. G. GOSLING, MD, *Chairman*

The Committee on Scientific Radio and Television continues to produce radio tapes. "Prescription for Health," a 15-minute tape, is sent each week to over 40 stations in Michigan. William Ledger, MD, is now hosting the series, replacing George Lowrey, MD.

The Committee conducted a survey of stations receiving the tapes this past year and found that they are welcomed by the stations and used regularly.

Our series of five minute tapes, called "Medical Talk," has been discontinued because of difficulty in programming and arranging for participants.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, commended the Committee and encouraged them to expand their programs in several areas.

THE HOUSE approved the report of the Reference Committee.

COMMITTEE ON VENEREAL DISEASE CONTROL

BENJAMIN SCHWIMMER, MD, *Chairman*

The Committee considered and made recommendations as follows:

RECOMMENDATION ONE: That The Council support serologic reporting of every positive STS by registered laboratories reporting to local health departments or to the Michigan Department of Public Health.

RECOMMENDATION TWO: That The Council adopt a policy that every physician who diagnoses and/or treats a case of venereal disease should report it to the health department or jurisdiction.

RECOMMENDATION THREE: That The Council refer to the Committee on Legal Affairs the recommendation of this Committee that any state hospital licensure law should include a requirement that all admissions to the in-patient services receive an admission blood test for syphilis.

RECOMMENDATION FOUR: The Committee on Venereal Disease Control requests the help and the support of the Council through the Committee on Legal Affairs in efforts to encourage the State Government of Michigan to recognize its responsibility in the diagnosis, treatment, and control of venereal disease, and to make meaningful appropriation toward this end.

The Committee's recommendations were not approved by The Council and at the present time a committee of The Council is meeting with the Chairman. Some or all of these matters may again be considered by the Committee and/or The Council.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, Harry A. Towsley, MD, Chairman, reported as follows:

"The Reference Committee commends the Committee on Venereal Disease Control for their far-reaching concern in the control of venereal diseases in the State of Michigan. The Reference Committee is not in a position at this time to give its full acceptance to the report for, as indicated, a committee of The Council is meeting with the Chairman of this Committee; and, since no further information is available, no action could be taken."

THE HOUSE adopted the report of the Reference Committee.

17. Reports of House of Delegates Committees

COMMITTEE ON CERTIFICATES OF COMMENDATION

Alfred H. Whittaker, MD, *Chairman*

The House of Delegates established the "MSMS Certificates of Commendation" at its 1961 session. The Delegates instructed that the awards "may include both scientific and/or public service, and may be awarded to one or several physicians annually who distinguish themselves in the medical profession."

The 1962 House of Delegates presented the first such "Certificates of Commendation" to four distinguished Michigan doctors of medicine who had been recommended by the Committee. These honorees were Jerome W. Conn, MD, Ann Arbor; G. D. Cummings, MD, Lansing; Charles S. Kennedy, MD, Detroit; and Robert L. Novy, MD, Detroit.

In 1963, the House of Delegates approved the report of the Committee and presented certificates to Forest D. Dodrill, MD, Bloomfield Hills; Charles J. Jentgen, MD, Detroit; John M. Sheldon, MD, Ann Arbor; and Homer H. Stryker, MD, Kalamazoo.

The 1964 House presented the certificates to Goldie B. Corneliuson, MD, Lansing; John S. DeTar, MD, Milan; Robert Heavenrich, MD, Saginaw; Norman F. Miller, MD, Ann Arbor; E. Gifford Upjohn, MD, Kalamazoo; and Orus R. Yoder, MD, Ypsilanti.

In 1965, the House approved Certificates to Fred J. Hodges, MD, Ann Arbor; Traian Leucutia, MD, Detroit; and Remus J. Robinson, MD, Detroit.

In 1966, the House presented awards to Arthur C. Curtis, MD, Ann Arbor; Lionel L. Davis, MD, Mt. Pleasant; Mark Marshall, MD, Ann Arbor; Harold J. Meier, MD, Coldwater; Ralph H. Pino, MD, Detroit; Alfred B. Swanson, MD, Grand Rapids, and Harry A. Towsley, MD, Ann Arbor.

The Committee this year again invited every component medical society to nominate one or more candidates. This year the Committee had more nominees than in any of the previous years. In its deliberations, the Committee considered 12 Michigan physicians, nominated either by their county medical society or by members of the Committee. The accomplishments of each were carefully reviewed.

The Committee is proud to present for consideration by the 1967 House of Delegates the names of six distinguished Michigan doctors of medicine for Certificates of Commendation. They are: Frank J. Busch, MD, Saginaw; W. H. Huron, MD, Dickinson-Iron; Frederick Margolis, MD, Kalamazoo; David I. Súgar, MD, posthumously, Wayne; Raymond W. Waggoner, MD, Washtenaw; and Charles H. Wright, MD, Wayne. Brief biographic information follows about each man:

Frank J. Busch, MD:

General practice, Saginaw; born Gladwin, Michigan, August 15, 1910; premedical education, University of Michigan; B.S. and M.D. (1935) degrees, Northwestern University Medical School; postgraduate study, University of Michigan School of Medicine.

President (1955), public relations chairman (1956-60), member of Ethics Committee (15 years), Saginaw County Medical Society; chairman of Advisory Committee to Saginaw County Medical Assistants Society and Michigan State Medical Assistants Society (1955-56); member, Public Relations Committee, Michigan State Medical Society; arranged for grant to establish a center for alcoholics in Saginaw.

Chief of staff (1958-60), chief of general practice (1950-59), hospital executive staff (1948-62), Saginaw General Hospital; member of program committee, Michigan Clinical Institute, 1957; medical director, Saginaw County Infirmary and Infirmary Hospital (since 1943).

Member, boards of directors, Chamber of Commerce (1957-58), Community Chest, Adult Mental Health Clinic, Retail Merchants Credit Bureau (1957-present), St. Francis Home; medical consultant, Family Society, Catholic Charities; medical advisor, Visiting Nurse Association; member, Advisory Board, Michigan Blue Cross (1959-63); member, American Academy of General Practice.

Recipient of Saginaw Chamber of Commerce Community Service Award (1967). Affiliated with General, St. Mary's, and St. Luke's hospitals in Saginaw. Doctor Busch has personally given much financial aid to many young physicians.

Willis Herbert Huron, MD:

General practice, surgery, Iron Mountain; born Tipton, Indiana, June 23, 1900; pre-medical education, Purdue University; B.S. degree (1922), Ohio State University; M.D. degree (1926), Ohio State University Medical School.

Served in United States Navy (1918).

Member, The Council (ten years); MSMS delegate to American Medical Association (five terms); member, boards of directors, Michigan Blue Shield, Michigan Division of the American Cancer Society; member, Executive Committee, Upper Peninsula Division, American Cancer Society; past president, Upper Peninsula Medical Society; president, secretary, Dickinson-Iron County Medical Society; member, School Board (four years).

Consultant, Veterans' Administration Hospital.

Member, Trauma Committee, American College of Surgeons; Alpha Kappa Kappa; director, Chamber of Commerce; past president, Rotary International; member, American Legion; Elks Club.

Awards include the Annual National-Divisional Award, Michigan Division of the American Cancer Society, and Citation of Merit, Michigan Medical Service.

Frederick J. Margolis, MD:

Pediatrics, Kalamazoo; born Pittsburgh, Pennsylvania, June 20, 1915; B.S. degree (1936), University of Pittsburgh; M.D. degree (1940), Wayne State University School of Medicine.

Medical director, United States Public Health Service (1953-55).

Delegate to MSMS House of Delegates (1966); vice chairman, MSMS Committee on Child Welfare (1964-67); consultant, MSMS Committee on Family Life Education; charter appointee and president (1958-65), Kalamazoo Board of Human Relations; member of boards, Kalamazoo-Constance Brown Hearing Society (1962-65), Michigan Children's Aid Society (1959-63); president (1966-67), Kalamazoo Academy of Medicine.

Director, Audio-Visual Medical Unit, and clinical assistant professor of medicine, Wayne State University School of Medicine.

Responsible for an exhibit on ipecac in poisoning of children, presented to American Academy of Pediatrics in 1964, and for exhibit on tetracycline research and balance studies for American Medical Association; principal investigator, seven-year research project, "Fluoride: Effect on Dentition When Given in Infancy."

Member, American Academy of Pediatrics.

Doctor Margolis is nationally recognized for his film on sex education, "Parent to Child About Sex," recently presented before the American College of Obstetrics and Gynecology.

David I. Sugar, MD:

Internal medicine, Detroit; born, Chicago, Illinois, 1894, died July 4, 1966; M.D. degree (1921), University of Michigan School of Medicine.

President (1960-61), trustee (1961-66), chairman of Board of Trustees (1964-66), Wayne County Medical Society; editor (1933-37, 1958-59), associate editor (1950-56), *Detroit Medical News;* delegate to MSMS House of Delegates; chairman, MSMS Section on Internal Medicine; past president, Detroit Physiological Society.

Instructor in internal medicine, Wayne State University Medical School.

Senior attending physician, Delray General Hospital, Detroit; associate attending physician, Detroit General Hospital; life member, Michigan State Medical Society.

Raymond W. Waggoner, MD:

Psychiatry, Ann Arbor; born Carson City, Michigan, August 2, 1901; premedical education, Highland Park Junior College and University of Michigan; M.D. degree (1924), University of Michigan School of Medicine; post-graduate study, D.Sc. degree (1930), University of Pennsylvania Graduate School of Medicine. Commonwealth Fellow (1926-29).

Director, Neuro-psychiatric Institute, University of Michigan Medical Center; associate professor of neurology and neurologist (1932-36), professor of psychiatry and chairman of Department of Psychiatry (1937-present), University of Michigan School of Medicine; chairman, Senior Medical Staff, University Hospital.

President, American Association of Chairmen of Departments of Psychiatry and of the American College of Psychiatrists; member, Academy of Psychoanalysis, American Psychiatric Association, Group for the Advancement of Psychiatry, National Board of Medical Examiners, American Bar Foundation.

Special consultant to State Department; advisor to Director of the Selective Service; consultant to the Surgeon General, Defense Department, and to Veterans' Administration.

Charles H. Wright, MD:

Obstetrics and gynecology, Detroit; born Dothan, Alabama, September 20, 1918; B.S. degree (1939), Alabama State College; M.D. degree (1943), Meharry Medical College; fellow, American College of Surgeons and American College of Obstetrics and Gynecology.

President, International Afro-American Museum Committee, African Medical Education Fund; member, National Medical Association; life member, National Association for the Advancement of Colored People; member, Ethics Committee, Wayne County Medical Society, an the Committee for the Medical Service Bureau.

Assistant clinical professor of obstetrics and gynecology Wayne State University School of Medicine.

Spent two months in 1967 on the *Hope* ship as obstetrician and gynecologist in Columbia, South America. Ha surveyed facilities for Agency for International Development, State Department, in Nigeria, Liberia, and Sierr Leone in 1964, Dahomey, West Africa, in 1965. Manne first aid stations in 1965 "Battle of Selma." Author o successful Easter play, "Were You There."

Named 1966 "Man of the Year" by the Nu Omeg chapter of Omega Psi Phi; 1965 "Doctor of the Year" b the Detroit Medical Society.

Affiliated with Highland Park General Hospital an Hutzel, Mercy, Grace, Sinai, Women's, and Boulevar General Hospitals, Detroit. Doctor Wright is chief o obstetrics and gynecology at Boulevard Hospital.

The House of Delegates last year adopted several recommendations of a reference committee and they wer incorporated in the Committee work this year.

Consideration was given alike to university-based physicians and practicing physicians.

The summaries this year were expanded to provide additional information so the delegates could better understand why the nominees had been chosen. Each nominee has made outstanding contributions to medical organizations; two, especially, have made valuable contributions in medical education; and four of them, especially, were chosen for their unselfish service to their community, state, nation and the world.

The Committee is pleased to report that this year the component societies did keep the nominations confidential so none of the nominees not chosen this year was embarassed.

The Committee would respectfully suggest that the 1967-68 committee members should be selected as soon as possible so they can begin their work early in the new year.

THE HOUSE, acting as a committee of the whole, adopted the report of the Committee.

COMMITTEE ON CONSTITUTION AND BYLAWS

Robert M. Stow, MD, *Chairman*

Refund of Dues to Expelled Members. The attention of this Committee was directed to an apparent omission in the MSMS Bylaws regarding refund of dues to members who are expelled. Some county medical society bylaws do provide for pro-rata refund of dues to an expelled members and thus, on occasion, a conflict between the state and county practices arises. The Council reviewed a specific case in point and suggested that the Constitution and Bylaws Committee resolve this question.

The Committee recommends that Section 4 of Chapter 4 of the Bylaws be amended to read as follows:

"Sec. 4. DEATH-EXPULSION — Upon the death or expulsion from membership of a member who has prepaid dues to this Society or to his component county society for any period beyond the quarter year in which his death or expulsion occurs, such excess shall be refunded by the respective Societies to the personal representatives of the deceased member or to the expelled member as the case may be."

Deferred Constitution and Bylaws Amendments from 1966 Committee Report. The report of the 1966 Constitution and Bylaws Committee was presented to the House last year and a motion was adopted to approve the report. However, due to a procedural technicality the report was deferred for consideration until the next meeting of the House. Therefore the following 1966 committee report is being submitted to the House as part of the 1967 committee's report, for final action.

COMMITTEE ON CONSTITUTION AND BYLAWS — 1966

C. J. France, MD, *Chairman*

While the Committee conducted only two meetings, on June 7 and August 2, 1966, the importance of this House of Delegates Committee and the work done by this Committee is evident in this annual report.

After careful deliberation, the Committee recommends the following actions to the 1966 House of Delegates.

1.) Change of name of Committee on Highway Accident Prevention to Committee on Highway Injury — "That subdivision (c) of Section 1 of Chapter 12 of the Bylaws be amended by striking out the words 'Committee on Highway Accident Prevention,' and substituting therefor the words 'Committee on Highway Injury.'"

2.) Implementation of medical staff surveys of hospitals — "That, inasmuch as this matter will be brought before the House of Delegates in The Council's report, until the House of Delegates acts on this proposal this matter is not in the area of responsibility of this Committee."

3.) Scientific Committees — "That a review be made by The Council of the necessity for continuation of scientific committees to determine the possibility of combining or eliminating those committees that have not been active in the past few years." Informational data previously compiled by the staff secretary of this Committee is available to The Council.

4.) Structure of Advisory Committee to the Executive Director — "That Section 3 of Chapter 10 of the Bylaws be amended by striking out subdivision (d) thereof and substituting therefor the following:

> "(d) The Advisory Committee to the Executive Director shall consist of the President, the President-Elect, the Speaker of the House of Delegates, the Chairman of The Council, the Chairman of the Finance Committee, the Treasurer and the Secretary. The Chairman of The Council shall be Chairman of the Committee. The duties of the Committee shall be to advise and counsel with the Executive Director and to report to The Council concerning matters of administration and personnel."

5.) Assistant Treasurer and Assistant Secretary — "That the adoption of the following two amendments to the Constitution be recommended:

> "Amend Section 1 of Article IX of the Constitution by inserting immediately following the semicolon after the word 'Treasurer' the words 'an Assistant Treasurer'; and by inserting immediately following the semicolon after the word 'Secretary' the words 'an Assistant Secretary';
>
> "Amend Section 3 of Article IX of the Constitution by striking out from the last sentence thereof the words 'The Secretary and the Treasurer' and substituting therefor the words 'The Secretary, Assistant Secretary, Treasurer and Assistant Treasurer.'

"Further, to submit *as information* to the House of Delegates the following three amendments to the Bylaws to implement the Constitutional changes immediately above. The Committee recognizes that these amendments to the Bylaws cannot be adopted at this year's Session and that a layover of one year is necessary, pending adoption of the Constitutional amendments.

Excerpt from *Digest of Proceedings, House of Delegates*, 1966. (*Michigan Medicine Supplement*, December, 1966, pages 60, 61.)

> "Amend Section 12 of Chapter 9 of the Bylaws by striking out the words 'Secretary and Treasurer' from the first sentence thereof and substituting therefor the words 'Secretary, Assistant Secretary, Treasurer and Assistant Treasurer.'
>
> "Amend Chapter 13 of the Bylaws by renumbering the present Section 7 as Section 8, the present Section 8 as Section 9, the present Section 9 as Section 10, the present Section 10 as Section 11, and by adding a new Section 7 to read as follows:
>
> "Sec. 7 *Assistant Treasurer and Assistant Secretary* — The Assistant Treasurer shall perform such duties of the Treasurer and the Assistant Secretary shall perform such duties of the Secretary as shall be directed by The Council. The Council may require either or both to be bonded in amount fixed by The Council, the cost thereof to be paid by the Society.
>
> "Amend Section 1 of Chapter 10 of the Bylaws by striking out the words 'Secretary, a Treasurer' from the second sentence thereof and substituting therefor the words 'Secretary, an Assistant Secretary, a Treasurer and an Assistant Treasurer.'"

6.) Judicial Commission — "That the House of Delegates approve the following amendment:

> "Amend Chapter 11 of the Bylaws by striking out Section 1 thereof and substituting the following:
>
> "Sec. 1 *Composition — Qualification* — The Judicial Commission shall be composed of ten members, each of whom shall be a voting member of the Society in good standing. No member of the Judicial Commission shall, during his tenure of office, hold any of the following offices or positions: Speaker or Vice-Speaker of the House of Delegates of this Society, Councilor of this Society, member of an ethics, grievance or mediation committee or member of the governing board of his component society."

7.) Committee on Michigan Medical History — "That a Committee on Michigan Medical History become a standing committee of the Society by amending the Bylaws as follows:

> "Amend Section 1 of Chapter 12 of the Bylaws by adding a subdivision (j) to read as follows:
>
> "(j) The Committee on Michigan Medical History shall consist of a chairman and not more than seven members including the Historian of the Society and at least one professor who teaches medical history in a Michigan medical school. It shall be the duty of the Committee to assist the Historian in summarizing and preserving Centennial and other historical materials, to explore and make recommendations with respect to historical projects, to encourage and assist component county societies in projects in the field of medical history and to assist the Publication Committee in the dissemination of historical materials."

8.) Eighth delegate to the American Medical Association — "That the following amendment to the Bylaws be recommended:

> "Amend Section 11 of Chapter 9 of the Bylaws by adding a paragraph to read:
>
> "Should the Society become entitled to one or more additional delegates subsequent to the annual session of the House of Delegates in any year, such additional delegate or delegates shall be designated and accredited by The Council to serve until the next annual session. In filling such offices, alternate delegates shall be designated in order of their seniority as defined in this Section."

The Chairman takes this opportunity to thank the members of the Committee, Legal Counsel and MSMS staff for their fine and diligent work.

THE 1966 REFERENCE COMMITTEE on Constitution and Bylaws, James D. Fryfogle, MD, Chairman, made the following recommendations regarding the eight items contained in the Annual Report of the Committee on Constitution and Bylaws

Item 1. Change of name of Committee on Highway Accident Prevention to Committee on Highway Injury. The Reference Committee recommended approval.

Item 2. Implementation of Medical Staff Surveys. The Reference Committee concurred in the Committee's recom-

mendation of no action, since this matter will be acted upon by the House through other reports.

Item 3. Scientific Committees. The Reference Committee recommended approval.

Item 4. Structure of Advisory Committee. The Reference Committee recommended approval.

Item 5. Assistant Treasurer and Assistant Secretary. The Reference Committee stated that since this required an amendment to both the Constitution and the Bylaws, both would have to lay over until the 1967 Session of the House of Delegates.

Item 6. Judicial Commission. The Reference Committee recommended approval.

Item 7. Committee on Michigan Medical History. The Reference Committee recommended approval.

Item 8. Eighth Delegate to the AMA. The Reference Committee recommended approval.

THE 1966 HOUSE adopted the report of the Reference Commitee. Subsequently, however, Parliamentarian H. M. Golden, MD, noted that Bylaws changes must be presented at one meeting of the House and laid over for one meeting before being acted upon. In the Parliamentarian's opinion, this had not been done in the case of the Annual Report of the Constitution and Bylaws Committee just acted upon by the House. Although there was no question of parliamentary procedure, but rather of interpretation of the existing Bylaws, the Speaker ruled that the report would be laid over until the next regular meeting of the House.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. Jackson France, MD, Chairman, recommended approval of the 1967 and the 1966 reports.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO DETERMINE MONETARY VALUE OF UNIT OF RELATIVE VALUE SCALE

Ross V. Taylor, MD, *Chairman*

The Committee met on August 23 and considered the following: 1) The 1967 revisions of the Michigan Relative Value Study; 2) the variable fee program of Ohio Blue Shield; 3) new developments in governmental agency payments to physicians; 4) cost of living comparison; and 5) the new variable fee program of Michigan Medical Service.

The Committee conferred with Ben R. VanZwalenburg, MD, Chairman of the Committee on Relative Value Study, regarding this year's revisions in the Michigan RVS and with Mr. Stevenson and Mr. Novick of Michigan Medical Service regarding the new Michigan Blue Shield variable fee program. The discussions developed several major facts and conclusions.

The determinations of unit values in the RVS are averages and it is recognized that some values in different practices are both higher and also lower in determining any averages.

The 1967 RVS presents a few changes in Surgery, Radiology, Pathology and Laboratory. There were some major changes in the Medical Section and these were primarily in refining the definitions and coding of services. The importance of having adequate coding and definition of services was stressed since the major use of the RVS in the future, assuming that most reimbursement for services will be based on the "usual and customary fee" principle, will be in the *use of the codings to establish the service rendered* and therefore the individual profiles for physicians based on the charges for services as defined by the coding and definitions of services.

It was noted, however, that appendectomy had been changed from 30 to 35 units and that eye examinations with refraction had been changed from 3 to 4 units. Since the original RVS inter-related procedures and used the procedure of appendectomy as a primary reference point, it was pointed out that on this basis all unit values might therefore be considered as requiring a similar 16% to 33% upward revision. The discussion pointed out the fallacy of any fixed inter-relationships between the four major sections of Medicine, Surgery, Radiology and Pathology and Laboratory. The discussion also brought out the fact that the RVS Committee had essentially worked with a basic philosophy of a fixed conversion factor and used variations in unit values to reflect variations of changes in practice.

The cost of living indices were considered and it was noted that most surveys agreed that between 1964 (when The Council first approved the $5.00 conversion factor) and the present 1967 — a time interval of approximately 3 years — the cost of living had increased approximately 10%. On this basis a 10% increase in the conversion factor would seem realistic. However, the functions of the RVS Committee seemed to obviate any present changes in the conversion factor. This conflict of committee functions seemed to make some change in policy a necessary requirement for the future.

The *Medical Economics* article, "The Big Switch in Blue Shield Benefits" was reviewed in reference to the variable fee programs under study or use by Michigan Medical Service and other Blue Shield plans. The following quotes were taken out of context: "In Ohio we pay *every* doctor his usual fee. And I mean the *doctor's* usual fee, not the usual fee of his colleagues". Also, "Van Hoth thinks that Blue Shield plans can maintain actuarily sound packages without reverting to ceilings of fees, 90th percentile cutoff, or even the comparing of a doctor's fees with those of other physicians in his area".

Michigan Medical Service representatives stated that Medicare charge pattern profiles plus Michigan RVS had been used to determine the actuarial basis of the premium levels for their variable fee program. They also stated that no determination of percentile cutoff in the range of charges in any area has as yet been determined. It was generally realized that the variable fees program which seems superficially to give a blank check to physicians actually could in the future lead to a fixed schedule which would be determined entirely by Michigan Medical Service. It was not satisfactorily determined whether either the RVS Committee or Michigan Medical Service had weighed each procedure according to the frequency of its performance within the state in establishing either unit values or the cutoff point in administration of Medicare.

The question was raised as to whether any percentile cutoff in a variable fee program, say of 90%, would therefore imply that the 10% outside of the screen would automatically be indicative of unfair or unreasonable charges. The fact was discussed that in some areas of practice, reimbursement would always be approximately 100% and the question was raised as to how this would affect the determination for the other areas of practice of any cutoff level.

Finally, in discussing governmental programs and the use of "usual and customary fees", it was noted that while most governmental agencies were moving to the "usual and customary fee" concept, there were at present three governmental programs which were required by law to use the latest "Michigan Uniform Fee Schedule for Governmental Agencies." There were: (1) Vocational Rehabilitation Office of the State Department of Education; (2) Department of Public Health; (3) Crippled Children Commission. It was noted that the 1965 "Red Book" does not contain a section which permits radiologists to bill separately for their services. It therefore seems advisable that the actions of the 1966 House of Delegates to use the 1966 RVS with a "conversion factor of not less than $5.00" as the guideline for payment with governmental agencies be reaffirmed for administrative purposes for those agencies which require use of the "Michigan Fee Schedule for Governmental Agencies" in their payment mechanism. No new action in this regard seemed necessary in view of the previous actions of the House of Delegates. The 1966 RVS does permit radiologists to bill separately for their services.

Based on the deliberations as noted, the following recommendations are made:

(1) That there should be complete separation of the four major sections in any future determinations of conversion factors.

(2) That there should be study of the advisability of a separate section of pediatrics in the future planning of the RVS Committee.

(3) That the functions of the Committee to determine an RVS conversion factor be given to the RVS Committee since only the RVS Committee can determine whether they are going to use a relatively fixed conversion factor with appropriate periodic variation of all unit values, or whether the conversion factors will vary periodically with relatively few unit value changes.

(4) That the 1967 Michigan Relative Value Scale be used as the standard basis for defining and coding medical services in Michigan.

(5) That profiles of physicians, as developed by Michigan Medical Service, should be based on the latest revisions of the RVS and should reflect the individual practice of each physician.

(6) The definition adopted by the House of Delegates in 1966 through Resolution 16 and amended by the House of Delegates be reaffirmed and utilized in administration of the individual physician profiles.

(7) Since a majority of governmental agencies and some insurance carriers, including Michigan Medical Service, are moving to offer payment for services on a "usual and customary fee basis" that no change in the present $5.00 conversion factor be made at this time.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended that the report be accepted.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL STAFF SURVEY OF HOSPITALS

R. L. Mainwaring, MD, *Chairman*

This Committee was established by the 1966 House of Delegates to supplement the work of the Joint Commission on Accreditation of Hospitals. The Committee is to implement a medical staff survey of Michigan hospitals when such a survey is required by the medical staff of the hospital or its staff executive committee.

The Committee has studied the survey techniques of the Joint Commission on Accreditation as well as the California Medical Association's voluntary medical survey program. Based upon these studies, the Committee is now establishing its own survey criteria so that it can meet its responsibilities.

In the interests of efficiency and effectiveness, the Committee feels it must operate under the following guidelines.

1. The role of this Committee will be to survey medical staffs upon appropriate request as outlined by the House of Delegates, but that such requests must relate to a specific staff problem(s) as it would not be advisable or feasible for this Committee to do general surveys.
2. That all survey requests from hospital medical staffs must be addressed to this Committee via the MSMS Council and must receive Council approval before the Committee will act.
3. After the Committee has conducted a survey and made recommendations to the hospital staff involved, it will report back to The Council to the effect that it has completed its work.
4. Since this Committee is not composed of members that represent all branches of medicine, it must have the authority to call in consultants when needed.

The Committee recommends that these guidelines be approved by the House of Delegates.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended approval of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROCEDURES OF THE HOUSE OF DELEGATES

Noyes L. Avery, Jr., MD, *Chairman*

This committee was first established by resolution adopted in 1963 and has been reappointed annually by the Speaker since that date. Each year, including the current one, the committee has formulated recommendations to the Speaker designed to improve the efficiency of the operations of the House of Delegates.

Emphasis has continually been placed upon meeting schedules which will permit ample time for the delegates to fully consider matters brought before them. This frame of reference was again adhered to in reviewing order of business for the 1967 meeting of the House of Delegates.

The Committee also considered the 1967 "Regional CPC" meetings as a valuable adjunct to the Councilor District Conferences, and recommends that a spring series of such meetings annually would be helpful to delegates and alternates. A slightly different and more expansive recommendation has been made to the 1967 House of Delegates by the House Committee on Study of Multi-County Medical Societies.

The Speaker this year assigned to the committee Substitute Resolution 25, 1966 House of Delegates, which combined two separate resolutions suggesting a change in the meeting date of the MSMS House of Delegates from early fall to spring. As a result, the committee surveyed meeting practices of all state medical societies and 45 major national specialty organizations. The survey disclosed that during the months of April, May, and June two-thirds of all meetings are held, indicating that these are by far the most popular months but also suggesting that the demand for program participants for scientific sessions would be acute during this period.

The survey also disclosed the fact that September and October are the next most popular dates for state society and specialty organization meetings, with eleven being held in September and ten in October. A more detailed analysis of these two months shows that the least conflict with other meetings would occur (assuming that the pattern of 1966-67 is usually followed), with a meeting scheduled when possible between the last few days of September and the first few days of October.

The committee recommends that the MSMS not separate its House of Delegates from its Annual Scientific Session, and that if the meeting date is changed this should be done for both meetings and simultaneously.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles-Meyers, MD, Chairman, recommended approval of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE

William M. LeFevre, MD, *Chairman*

This Committee was established by the 1966 House of Delegates and was authorized to:

1) study current upward trend in claims in professional liability insurance;

2) review the causal factors;

3) study revisions in rates and eligiblity;

4) investigate possible measures which might slow or reduce the claims increase;

5) study pre-trial and impartial expert plans such as that in operation in Pima County, Arizona;

6) report its recommendations to the 1967 House of Delegates together with constructive advice and suggestions designed to assist MSMS members in the handling of professional liability problems.

This Committee with MSMS Legal Counsel, has met with representatives of the Medical Protective Company, the largest insurer of doctors of medicine in Michigan, to study the matters outlined by the House of Delegates.

The Committee reviewed a three-year study of causative factors of medical professional liability cases in Michigan which was prepared by the Medical Protective Company, as follows:

Three-Year Study of Causative Factors Medical Professional Liability Cases — Michigan

Claimed Injury Condition or Cause	Per Cent of Cases
Errors in Diagnosis (Includes emergency room diagnosis, diagnosis by telephone, or failure to examine or x-ray patient)	14
Damage to oral structures (From anesthesia procedures)	13
Foreign bodies (Includes sponges, needles, other equipment or failure to remove alien materials)	12
Assault (Includes improper or lack of informed consent, undue familiarity, unnecessary surgery, use of excessive force)	11
Fractures (Includes failure to properly treat, poor results, or amputations)	10
Treatment of Female Reproductive System	10
Control of Patient (Includes leaving patient unattended or inadequately attended, or improperly restrained resulting in injury)	9
Drug Reactions	8
Injuries to nervous or circulatory systems	6
Reactions (other than drugs) (Includes burns from equipment or surface burns from medications)	5
Equipment Failures (Injuries caused by equipment failure or in improper working condition)	2

Present underwriting requirements of Medical Protective Company require that each physician is carefully underwritten on an individual basis as to 1) character, 2) licensure, 3) professional standing, 4) hospital affiliation, 5) claims and suit experience, and 6) county and state medical society affiliation.

Premiums were raised for various classes of physicians in 1966 because of high losses. Present rates are as follows:

MEDICAL PROFESSIONAL LIABILITY INSURANCE RATES

Area I: Genesee, Oakland & Wayne Counties. Area II: Rest of State.

CLASS 1: SPECIALIZING IN

Internal Medicine, Cardiovascular Diseases, Allergy, Neurology, Chest, Pediatrics, Pathology, General Practice (no Surgery or Anesthesia), Psychiatry (no shock therapy), Radiology or Dermatology (no X-Ray therapy).

LIMITS	$10,000 $30,000	$25,000 $75,000	$ 50,000 $150,000	$100,000 $300,000	$200,000 $600,000
Areas I & II	**$ 54**	**$ 68**	**$ 76**	**$ 82**	**$100**

CLASS 2: SPECIALIZING IN

Psychiatry (including shock therapy), General Practice (Performing normal deliveries or assisting in Surgery).

LIMITS	$10,000 $30,000	$25,000 $75,000	$ 50,000 $150,000	$100,000 $300,000	$200,000 $600,000
Areas I & II	**$ 66**	**$ 84**	**$ 93**	**$101**	**$123**

CLASS 3: SPECIALIZING IN

General Practice (doing Surgery or Anesthesia); Proctology; Ophthalmology.

LIMITS	$10,000 $30,000	$25,000 $75,000	$ 50,000 $150,000	$100,000 $300,000	$200,000 $600,000
Area I	**$190**	**$241**	**$266**	**$290**	**$353**
Area II	**$143**	**$181**	**$200**	**$218**	**$265**

CLASS 4: SPECIALIZING IN

Surgery, Urology, Thoracic Surgery, Cardiovascular Surgery, Colon and Rectal Surgery, Otolaryngology (excluding Plastic Surgery).

LIMITS	$10,000 $30,000	$25,000 $75,000	$ 50,000 $150,000	$100,000 $300,000	$200,000 $600,000
Area I	**$286**	**$363**	**$401**	**$437**	**$530**
Area II	**$213**	**$270**	**$299**	**$325**	**$395**

CLASS 5: SPECIALIZING IN

Obstetrics and Gynecology, Anesthesiology, Orthopedic Surgery, Plastic Surgery, Neurological Surgery, Otolaryngology (including Plastic Surgery).

LIMITS	$10,000 $30,000	$25,000 $75,000	$ 50,000 $150,000	$100,000 $300,000	$200,000 $600,000
Area I	**$356**	**$451**	**$499**	**$544**	**$660**
Area II	**$286**	**$363**	**$401**	**$437**	**$530**

PARTNERSHIP CHARGE

If you practice in partnership and desire coverage for your partnership liability, add 20 percent to premium listed above.

X-RAY THERAPY COVERAGE

Rates for X-ray therapy coverage are available upon request.

The following suggestions were made by the Medical Protective Company representatives as to what MSMS can do to help prevent claims and suits:

1) The physicians of the state should offer their assistance to the state legislative bodies to aid them in preparing legislation as to protect the plaintiff and defendant alike.

2) Physicians should always bear in mind that thoughtless remarks in the presence of plaintiff's attorneys could lead to their being ordered into court under very embarassing conditions.

3) Physicians should not promote or support medical legal panels. Plaintiffs' attorneys have promoted medical legal panels in as many areas as possible. They also promote medical legal symposiums. This gives publicity to the fact that doctors can be sued and encourages more suits to be filed.

4) County medical societies should aid insurance companies in their underwriting program.

5) Physicians should cultivate good personal relationships with their patients and fellow physicians.

The Committee studied joint attorney-physician review panels, such as that in operation in Pima County, Arizona. Under this plan a joint panel of physicians and attorneys, and sometimes prominent lay individuals, screen claims filed against physicians in that area. A pre-trial of the case is held with participation of the defendant physician and his attorney and the plaintiff and his lawyer. Witnesses are often included. On the basis of this hearing the panel makes a decision as to whether there is substantial evidence to warrant a claim. Many cases are then settled out of court or dismissed. Both parties agree in advance to be bound by the panel's decision.

The Joint Panel of Physicians and Attorneys has several hazards arising primarily out of the exposure of all the records of the case to the plaintiff's attorney at an early stage. It gives a test run of the case. Even if by legislative act, such as in New Jersey, lawyers agree not to represent that client in court if the ruling is against him, it does not prevent that client from obtaining another lawyer and using the confidential material divulged at the panel hearing.

Another obstacle to the successful operation of such a plan in Michigan would be that the Medical Protective Company, who insures the majority of the doctors in this area, is diametrically opposed. This Company has watched the operation of these plans in other parts of the country and its experience has been bad.

The Committee recommends that future problems in the area of professional liability insurance be brought to this Committee for any help that it might render.

A few such problems already have been referred to this Committee and have been settled in an amicable manner.

THE REFERENCE COMMITTEE on Public and Professional Relations, Paul T. Lahti, MD, Chairman, accepted the Committee's report, and recommended that the Committee be continued, and that the information in the report be published in Michigan Medicine.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON REAPPORTIONMENT

Philip K. Stevens, MD, *Chairman*

The Committee conducted a meeting on June 7, 1967, to review the interim report of its predecessor committee made to the 1966 House of Delegates and also the deliberations of the House Committee to Study Multi-County Medical Societies.

A thorough review of the distribution of doctors of medicine in Michigan, present composition of county medical societies and present patterns of representation in the House of Delegates, The Council, and the American Medical Association was also conducted.

The Committee considered that its charge should be examined in the light of developing recommendations which would be best for all of organized medicine in Michigan. It noted that the MSMS Constitution specifically states that MSMS is to be composed of county medical societies, that all must be represented in the House of Delegates, and that no matter what ratio is used for representation (presently 1:50) the basic impact upon "small" and "large" county societies would remain the same. It was concluded that perhaps the only ultimate solution to complete membership equality in House of Delegates representation would be to make every member a delegate (a representation ratio of 1:1).

Having carefully analyzed all available pertinent data, the Committee developed the following three recommendations for the consideration of the 1967 House of Delegates:

RECOMMENDATION ONE: That the House of Delegates retain the present provisions of the Constitution and Bylaws regarding representation in the House of Delegates.

RECOMMENDATION TWO: That existing Constitutional and Bylaws machinery be utilized by any component society or societies of MSMS which desires to alter its representation on The Council, MSMS.

In regard to Recommendation Two, the Committee noted that councilor-member representation varies from a ratio of 1:672 to a ratio of 1:79, but that provision is already made in the rules which govern MSMS to combine or divide component county societies or to in fact request a change in councilor districts themselves.

RECOMMENDATION THREE: That the MSMS House of Delegates accept as satisfactory the present method of selecting the MSMS delegation to the AMA.

In connection with Recommendation Three, the Committee noted that the number of delegates to the AMA permitted each state is based upon the Constitution and Bylaws of the AMA itself and not its constituent organizations. The Committee also noted that MSMS delegates to the AMA are elected "at large" and considers this method to be both democratic and appropriate.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles-Meyers, MD, Chairman, recommended approval of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO SELECT MICHIGAN'S OUTSTANDING PHYSICIAN

Gerald H. Rigterink, MD, *Chairman*

The 1964 House of Delegates took action "to establish annual recognition of Michigan's Outstanding Physician." The resolution outlined this award "as an annual recognition of a member of the profession, who is not necessarily a family physician, nor one advanced in years." The Delegates also adopted the report of the reference committee which instructed "that the Speaker annually appoint an ad hoc committee to make the selection from nominations submitted by component medical societies."

The 1965 House of Delegates approved the recommendation of the first committee and presented this new MSMS award to Franklin L. Troost, MD, of Holt, for 1964-1965.

The Committee to select the 1965-1966 recipient met several times to evaluate the candidates and selected William A. Hyland, MD, Grand Rapids, as its nominee. Doctor Hyland died before the Annual Session after a short illness, and the Delegates voted that the award be given posthumously to the highly respected Grand Rapids doctor.

The 1966-67 Committee received nominations from component medical societies. Each of the nominees has an outstanding record as a physician and a community leader. The Committee diligently studied the accomplishments and contributions of each man. The Committee recommends the name of Henry Cook, MD, Flint to the House of Delegates as "Michigan's" Outstanding Physician for 1966-1967."

A brief biography follows:

Henry Cook, MD, was born February 28, 1886, near Owosso, Michigan. He received his MD degree from the Detroit College of Medicine (now Wayne State University School of Medicine) in 1909; he was licensed in Michigan and began practicing in Flint that same year. He served as first lieutenant in the AEF Medical Corps in France during World War I.

Active in medical society affairs, Doctor Cook has served as MSMS President, 1937-1938; member of The Council, 12 years, and as Council Chairman; and Genesee County Medical Society President-for-a-day, January 7, 1960.

In 1959 the Michigan State Medical Society gave him a 50-year Award.

Doctor Cook is known for his many contributions to the field of education, specifically for his 36 years of service on the Flint Board of Education, serving four terms as president, and as a member of the Citizens' Advisory Committee to the Board of Education. In recognition of his many outstanding achievements in education, the auditorium of Northern High School in Flint was named for him.

For many years Doctor Cook served as examiner and consultant for the Flint Trolley Coach Company and as surgeon for the Grand Trunk Railroad.

He is a member of the Industrial Medical Association and is a past president of the Michigan Industrial Physicians Association.

Doctor Cook was a member of the Genesee County Tax Allocation Board for eight years and of the Flint Recreation and Park Board for 14 years. In addition, he belongs to the Elks Club, of which he is a 50-year member and past officer; Knights Templar, of which he is a life member; the American Legion; the Chamber of Commerce; and he is a Master Mason.

He is affiliated with Hurley, St. Joseph, and McLaren hospitals in Flint, and he has served as chief of staff at Hurley Hospital.

THE HOUSE, acting as a committee of the whole, adopted the report of the Committee and the following verbal presentation to the House of its Chairman, Doctor Rigterink:

"The Committee would like to suggest that all county medical societies, large and small, be encouraged to send in at least one nomination. It is also suggested that a notebook of news clippings, letters, and so on, be included to help document the nomination.

"This year one county medical society nominated three candidates. The Committee felt that such a procedure was entirely permissible, and each candidate was considered on an individual basis.

"The Committee to Select Michigan's Outstanding Physician received seven nominations, and hereby recommends that the House of Delegates recognize Dr. Henry Cook, of Flint, Michigan, for this honor. Dr. Cook was nominated by the Genesee County Medical Society, and his outstanding careeer has been well documented."

COMMITTEE TO STUDY FEASIBILITY OF COLLECTING AND REVIEWING RESOLUTIONS PASSED BY OTHER STATES' HOUSES OF DELEGATES

Sidney Adler, MD, *Chairman*

The Committee was created in 1966 when the House of Delegates adopted Resolution 59 as amended by the Reference Committee on Miscellaneous Business:

> RESOLUTION 59
>
> Establishment of an MSMS House of Delegates Committee to Study Resolutions Passed by Other State Medical Society Houses of Delegates.
> Introduced by Harold F. Falls, MD.
>
> WHEREAS, there does not exist a mechanism whereby there is available for the study and review of resolutions passed by other state houses of delegates, either on a state or national level, and
>
> WHEREAS, many of these resolutions may contain data and information applicable to medicine in Michigan, therefore be it
>
> RESOLVED: That the Speaker of this House of Delegates appoint a committee to be assigned the responsibility of studying the feasibility of collecting and reviewing resolutions passed by other state houses of delegates with the intent that matters of importance to MSMS be reported to this House.
>
> RESOLVED: That the AMA likewise be petitioned to establish a central agency wherein all resolutions passed by state medical society houses of delegates be deposited and be available for study by all component and county medical societies.

The Committee has reviewed resolutions passed by other large state medical societies such as California, Illinois, New York and Pennsylvania. Our conclusions based upon this review are:

1) Many of these resolutions reflect areas of concern shared by the larger state medical societies. This is especially true with respect to governmental medical care programs.

2) Information of this type would be helpful to the deliberation of the MSMS House of Delegates as well as The Council and various Society committees.

3) To be usable, these resolutions must be catalogued according to their application to medicine on federal state and local levels.

4) This catalog should be further broken down under such headings as Government Medical Care Programs, Hospital Relations, Insurance, Medical Education, etc. (A more detailed breakdown is presented in Addendum "A" of this report.)

The Committee reviewed the action of the AMA House of Delegates which failed to pass Resolution 12 on establishment of an AMA central agency on resolutions adopted by constituent societies. This Committee feels, however, that there is real need for such a service from the AMA and efforts to bring this about must continue.

The Committee in its deliberation also noted that most state medical societies hold their annual meeting in late winter or early spring. This has the great advantage of letting their house of delegates consider the latest developments in the health care field, thus enabling their AMA delegations to participate more efectively in the June meeting of the AMA. The Committee noted that it is most difficult to hold committee meetings in the summer months. As a result, many important new developments are not given adequate study before the September meeting of the MSMS House.

Based upon the foregoing we make the following recommendations to the House of Delegates:

1) That the delegation to the AMA be instructed to again introduce a resolution that would establish a clearing house at the AMA level for resolutions passed by state medical societies.

2) That until this is accomplished, the MSMS headquarters office establish a clearing house for resolutions passed by the larger state medical societies such as California, Illinois, New York and Pennsylvania, etc.

3) That the House of Delegates change its annual meeting from September to spring.

4) That MSMS adopt a fiscal year that begins either January 1 or July 1 as do most business and governmental agencies.

Addendum "A"

Study of Resolutions Passed by Other State Houses of Delegates Catalog Outline

- I. Federal
    - A. Governmental Medical Care Programs
        - 1. Title 18 and Title 19
            - a. Fee Schedules
            - b. Carriers
            - c. Direct Pay Authorization
            - d. Utilization
    - B. H.E.W.
    - C. National Institutes of Health
    - D. Heart, Cancer, Stroke
    - E. Rural Centers
    - F. Military Programs
    - G. Medical Facilities
    - H. Office of Economic Opportunity
    - I. Aid to Medical Education
- II. State
    - A. Public Health
    - B. Social Services
    - C. Workmen's Compensation
    - D. Medical Education
    - E. Medical Facilities
    - F. Blue Cross and Blue Shield
    - G. Mental Health
    - H. Nursing Homes
- III. Local
    - A. Department of Health

B. Department of Social Services
C. Poverty Programs
D. Medical Facilities
E. Hospital Emergency Rooms

THE REFERENCE COMMITTEE on Public and Professional Relations, Paul T. Lahti, MD, Chairman, recommended approval of Recommendations 1 and 2, recommended disapproval of Recommendations 3 and 4.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO STUDY FINANCIAL STRUCTURE OF MSMS

James D. Fryfogle, MD, *Chairman*

In 1966, this Committee presented its triennial report on the MSMS financial structure. In receiving the report, the House of Delegates reference committee "recommended the Committee continue, with as many of the same members as possible, and submit an annual rather than a three-year review of the MSMS financial structure."

The Committee defined its responsibilities as follows: It must 1) review all aspects of the financial structure of MSMS, 2) determine that monies are efficiently administered, and 3) assure itself that funds are adequate for the job to be done. The Committee decided not to comment on the worth and value of projects or activities since these are annually reviewed by the House through reports from The Council and committees.

In brief, the Committee's methodology of study was to assign various aspects of the overall review to individual members of the Committee with reports for full Committee consideration. It also held meetings with members of the Finance Committee, Treasurer John R. Ylvisaker, MD, and key members of the staff.

Data generated by the 1966 study is updated and will be found in the addenda to this 1967 report.

Financial Management Procedures.

The 1966 report reviewed in detail these new procedures developed by MSMS staff and a Detroit accounting firm.

The Committee commended the staff and The Council for adopting these financial control and budget procedures.

In 1967 the Committee again reviewed the effectiveness of the new systems and found them highly effective.

Internal Revenue Service Regulations.

Legal Counsel and Special Tax Consultant have under continual review a proposed new regulation re taxability of profit from publications of tax-exempt associations.

Income and Expense.

The committee has made a detailed analysis of the income and expense of MSMS for 1964, 1965, 1966 and 1967 (estimated). The gross figures appear in Exhibit A.

These figures reflect the financial impact of the Michigan Clinical Institute which was held only in 1964 of our study period. The MSMS discontinued the MCI beginning in 1965.

Although it is difficult to compare these figures because of the unusual expenditures of the Centennial celebration, the variation of exhibit sales (due to change of location between Grand Rapids and Detroit and decrease in demand) and the fluctuation in Journal advertising sales, it is evident that MSMS is operating within its income except for the Centennial year.

Sources of Income.

MSMS has four major sources of income — member dues, grants, exhibit sales and Journal advertising and reprint sales. (See Exhibit B.)

Dues income for 1964 was $490,769; for 1965 was $501,369; for 1966 was $558,000, and for 1967 (projected), $630,000.

Grants for special activities or projects also have increased during the study period. In 1964 grants totaled $1,700; in 1965, $14,035; in 1966, $16,255; and in 1967 (projected), $7,000.

Exhibit sales fluctuate depending upon the site of the Annual Session:

1964 (Detroit)	—	$25,891	
1965 (Detroit)	—	$45,312	
1966 (Grand Rapids)	—	$29,000	
1967 (Grand Rapids)	—	$24,500	(projected)

Advertising and reprint sales have decreased but appear now to be stabilizing:

1964	—	$60,954	
1965	—	59,509	
1966	—	70,300	
1967	—	77,000	(projected)

Expenses.

Like all business and associations, MSMS' cost of doing business continues to increase. A broad indicator of this increase is the BLS wholesale price index (using the 1957-59 base period) stood at 100.3 in December, 1963, and had risen to 106 by March, 1967. In specific instances prices tend to pyramid from wholesale to ultimate buyer. These increases reflect in the cost of equipment, supplies and services used in daily MSMS operations. For example, office supplies have increased in cost 10-15% on a per unit basis. Contracted printing costs have increased 10% since 1963. Window-washing services rose 12% since 1963. Bulk mail rates have climbed 20% since 1960. Property taxes have increased from $14,000 to $16,000 since 1963. Part-time secretarial hourly wage rates have increased 14% and competitive clerical wage rates have increased 16.8% since 1963.

The Council and management have taken major steps to hold costs to the most reasonable levels. Two examples: 1) Use of part-time secretarial help for peak work periods to minimize the number of full-time clerical staff and resulting supplemental benefit costs. 2) Installation of labor-saving and speed-production equipment to perform more efficiently.

Personnel.

The committee reviewed the MSMS staff and duties (See Exhibit C) and reviewed the wage scales, salaries and methods by which these are revised. The committee also reviewed the MSMS Personnel Policies and Procedures which detail the normal work rules, privileges and responsibilities of employees.

The committee was complimentary of these procedures and noted that compared with organizations having similar annual budgets, MSMS has a smaller number of staff and thus a lower percentage of its budget allocated for staff compensation.

Treasurer's Report

Treasurer Ylvisaker reviewed his report to The Council of July 13, 1967. This report contained recommendations to revise MSMS asset management together with the establishment of some basic policies of investment administration. This report was discussed and the Committee agreed in principle with the Treasurer's recommendations. The Committee felt, however, that Recommendations 1-b-(2) and 4-a should contain additional language which would clearly define the authority of The Council over the 5 investment trustees.

CONCLUSIONS

The Committee has up-dated its review of the finances of the Michigan State Medical Society. The monthly financial control and budget procedures (as presented to the Finance Committee of The Council) were reviewed by this Committee through June of 1967. After 1½ years of operation this systematic control of expense centers affords a forthright review of expenditures and is aligned with budgetary estimates.

The sources of income, housekeeping expenditures and personnel policies were reviewed in detail. Although the cost of doing business has increased, our 1967 income would appear adequate for our estimated budget. The size of MSMS staff to do the job is below that of comparable organizations with similar size budgets. The Committee commends management for the handling of these last two items.

We again caution, that while budgetary monies appear adequate for normal society function, major new programs or services would need new sources of funds.

A major change is proposed in the financial handling of our capital assets. An entire meeting and a portion of another were spent with our new Treasurer, Doctor Ylvisaker, and members of the Finance Committee of The Council, reviewing in depth this financial reorganization. Since this plan will be presented to the House of Delegates it will not be included in our report, but the 1967 Committee to Study the Financial Structure of the MSMS approves in principle this needed reform.

EXHIBIT A

Comparison of MSMS Gross Income by year

1964	1965*	1966	Estimated 1967
$600,830	$621,044	$672,955	$761,300

Comparison of MSMS Gross Expense

1964	1965*	1966	Estimated 1967
$586, 498	$707,948	$654,835	$704,305

* Centennial year

Note re Michigan Clinical Institute:

The Michigan Clinical Institute in 1964 produced income of $11,569, and expense of $12,590. The MCI was discontinued in 1965.

EXHIBIT B

INCOME OTHER THAN DUES

	1964	1965	1966	Estimated 1967
Rent & Misc. Sales	$ 4,330.06	*$ 7,129.26	$ 7,707.00	$ 7,300.00
Grants	–	** 1,000.00	16,251.00	7,000.00
Interest on invested funds	2,813.69	3,871.00	2,273.00	7,000.00
Annual Session Exhibits	25,891.00	***45,312.50	29,075.00	24,500.00
MCI	11,569.00	—	—	—
Journal Advertising	56,288.36	55,103.79	70,364.00	77,000.00
Reprints – Journal	4,665.91	4,405.32	1,108.00	7,500.00
Subscriptions other than members	1,513.12	**** 2,519.65	2,739.00	2,000.00
TOTAL	$107,071.14	$119,341.42	$118,550.00	$131,300.00

* $1500 Beaumont Books Sales
** For Healthmobile
*** Centennial
**** We began to charge life members

EXHIBIT C

MSMS PERSONNEL

Brenneman, Hugh W. – Executive Director
Tryloff, Warren F. – Associate Executive Director
Auer, Herbert A. – Managing Editor & Public Relations Director
Riley, M. A. – Legislative Representative
Campau, Richard M. – Director of Economic Research
Mehler, Herbert – Staff Assistant on Governmental Medical Care Programs
Wills, Ralph T. – Director of Community Relations, Public Relations Field Secretary
Schulte, Helen A. – Administrative Assistant
Hoheisel, Peter – Public Relations Assistant Detroit Regional Office
Roney, Robert J. – Controller
Hoover, Maynard J. – Production Manager
Brewbaker, Mary K. – Administrative Secretary
Davis, Vada L. – Administrative Secretary
Karker, D. Marjorie – Administrative Secretary
Taylor, A. Francine – Administrative Secretary
Snelgrove, Alice – Secretary-Writer
Kula, Irene – Secretary
McAfee, Sharon – Secretary
Berry, Margaret – Accounting & Membership Records Assistant
Congleton, Marsha – Receptionist-Stenographer
Merz, Helen – Receptionist-Stenographer
Stotenbur, Marcella – Stenographer

THE REFERENCE COMMITTEE on Ways and Means, S. N. Kelso, MD, Chairman, reported as follows:

"This Reference Committee approves in principle the recommendations of the Treasurer's report and also the recommendations of the Committee to Study the Financial Structure of MSMS. However, because of the newer concept of financing proposed, the Reference Committee feels that the members of the House of Delegates should have more time to better acquaint themselves with the proposed changes.

"Your Reference Committee recommends that a committee of the House of Delegates be appointed to further consider this proposal and further acquaint the county medical societies with the intent and implications of this proposal, the committee to be instructed to report back to the 1968 House of Delegates."

THE HOUSE amended the report so that it read, "This Reference Committee approves in principle the recommendations of the Treasurer's Report and also the recommendations of the Committee to Study the Financial Structure of MSMS." The House then adopted the report as amended.

COMMITTEE ON STUDY OF MULTI-COUNTY MEDICAL SOCIETIES

Thomas R. Kirk, MD, *Chairman*

The Committee, after distribution of a questionnaire to the presidents of all MSMS component medical societies, met on May 31, 1967. All recommendations of the 1966

Annual Report of the predecessor committee were noted to have been implemented or under study. The following recommendations are made to the 1967 House of Delegates:

First, that present county medical society boundaries should not be disturbed unless requested by the societies involved. (See recommendation 1, 1966.) The Committee feels that physician distribution throughout the state is such that any boundary realignment undertaken by the House of Delegates per se would disadvantage all physicians. The Committee further notes that the MSMS Constitution and Bylaws presently provide means whereby individual societies can institute procedures to either subdivide or combine with other county societies (see Article III, Sections 1 and 2 of the Constitution; Chapter 1, sections 1 and 2, Bylaws; and Chapter 10, section 9, Bylaws.) Legal Counsel has pointed out that no single county can comprise more than one county medical society, but a county society may comprise two or more counties.

Second, the Committee reiterates the statement of the 1966 committee that the "one man one vote" principle does not lend itself to MSMS organization, for the Society is a unicameral body and geographical distribution is desirable.

Third, the Committee recommends that MSMS develop, under the aegis of the Legal Affairs Committee, a formalized system for counseling with elected and appointed governmental officials patterned after the system used in Kentucky. (See recommendation 2, 1966.) This structure, called a "key man" method, matches at least one physician with each state and federal legislator and is coordinated by the state society's legislative committee; the Kentucky system has been blueprinted by that state and made available to the Multi-County Medical Societies Committee.

Fourth, the Committee recommends that four "Regional CPC" meetings, following the pattern of the 1967 meetings, be held each year commencing with calendar year 1968 and that the fourth such meeting be held each year on the afternoon of the day on which the House of Delegates convenes. (See recommendation 3, 1966.) Such meetings, it is felt, are of great value in both creating a forum for exchange of viewpoints between delegates of smaller county medical societies and as a means of orienting delegates to the business of the Society.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles-Meyers, MD, Chairman, recommended approval of the report, with the clarifying comment that the intent of the fourth recommendation is that "regional CPC meetings be held in four different areas."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTIONS

THE HOUSE adopted a motion that no new resolutions be introduced after the Monday night meeting except by approval of three-fourths of the delegates present and voting on the question.

RESOLUTION 1

Section Delegates, Right to Vote

Introduced by Hira E. Branch, MD

Whereas, the delegates representing the sections as provided in the Bylaws are duly elected, and

Whereas, such delegates cannot adequately represent their sections unless they have full powers of a delegate, and

Whereas, under the present rules these delegates have no right to vote, therefore be it

RESOLVED: That the Bylaws be modified as follows:

Chapter 9 — Section 1: Add sentence — "In addition the House of Delegates shall include the elected delegates of the various sections as described in Chapter 14 — Section 5."

Chapter 9 — Section 1 would thus read:

Composition — The House of Delegates shall be composed of members elected by the component societies. Each component society shall be entitled to send to the House of Delegates each year one delegate for each fifty voting members (active, life and retired) and one delegate for each additional major fraction thereof. Any component society having less than fifty members shall be entitled to send one delegate. In addition the House of Delegates shall include the elected Delegates of the various sections as described in Chapter 14 — Section 5.

Chapter 9 — Section 2: Omit, "and one Delegate from each authorized section."

Chapter 9 — Section 2 would thus read:

Delegates-At-Large-Ex Officio Members-The officers of this society, the members of The Council shall be ex-officio members of the House of Delegates but, with the exception of the Speaker and Vice-Speaker of the House of Delegates, shall be without power to vote therein. The Past-President shall be a member at large of the House of Delegates during the first year of Past-Presidency with the right to vote and hold office. All other Past-Presidents shall have the privilege of the floor, without the right to vote.

Chapter 14 — Section 5: Omit part of the last sentence after "each and to have the status, when seated, of an ex-officio member of the House of Delegates as provided in Section 2 of Chapter 9 of these Bylaws."

Chapter 14 — Section 5 would thus read:

Election of Officers and Delegates — At its annual meeting each section shall elect a chairman, a vice-chairman and a secretary, each of whom shall serve a term of one year. At the first annual meeting held by a section and thereafter at each alternative annual meeting, it shall elect a delegate and an alternate delegate to the House of Delegates of the Society, such delegate and alternate delegate to serve for terms of two years.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. Jackson France, MD, Chairman, recommended disapproval for the following reasons: (a) The effect of the resolution would be to give double representation to various sections of the Society disproportionately to the membership in such sections; (b) Specialty groups do have representation through their section delegates who are ex officio members of the House with power to speak before the House.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 2

Hospital Privileges

Introduced by Douglass A. Haddock, MD

Whereas, the primary obligation of all physicians is to render to patients quality medical care, and

Whereas, the public deserves the right to choose individual physicians, and

Whereas, these basic principles were agreed upon by the MSMS delegates in their meeting of September, 1966, when they passed Resolution 55, and

Whereas, Resolution 55 passed by that body stated only "that in the public and professional interest the House of Delegates of the Michigan State Medical Society support the principle of every ethical licensed physician having admitting and staff privileges commensurate with his training and skill in at least one accredited hospital," therefore be it

RESOLVED: That the Michigan Academy of General Practice offer a resolution to the next Michigan State Medical Society Meeting of the House of Delegates requesting the implementation of Resolution 55, 1966 House of Delegates, by the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended no action.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 3

Repeal of Basic Science
Introduced by Douglass A. Haddock, MD

Whereas, the State of Michigan is finding great difficulty in getting an adequate number of physicians, both general and specialist, and

Whereas, members of the State Legislature have been cognizant of this shortage of physicians for the State of Michigan, and

Whereas, the Basic Science Act has also stood as a barrier against getting more physicians for Michigan, therefore be it

RESOLVED: That the Legislature of the State of Michigan rescind the Basic Science Act.

THE REFERENCE COMMITTEE on State and Federal Legislation, James D. Frylogle, MD, Chairman, amended the resolved portion to read, "That the Legislature of the State of Michigan be urged to repeal the Basic Science Act", and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 4

Definition of Specialist
Introduced by Douglass A. Haddock, MD

Whereas, Michigan Blue Shield has requested information from physicians in order to determine their professional qualifications on the unwarranted assumption that Resolution 22 of the 1966 House of Delegates of the MSMS directs them to do so, and

Whereas, the MSMS House of Delegates, in this resolution, stated that this should be a function of the medical profession, and

Whereas, it is a well established policy of MSMS that equal fees be paid for equal services, therefore be it

RESOLVED: That The Council of MSMS be urged to request Blue Shield to discontinue its efforts to make such a determination.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, believed the carrier was required to provide such information and therefore recommended that the resolution be disapproved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 5

Rescind Resolution 22, 1966 MSMS House of Delegates
Introduced by Douglass A. Haddock, MD, Section on General Practice

Whereas, the MSMS House of Delegates has passed Resolution 22, defining a specialist, at its annual meeting, and

Whereas, the resolution was passed to differentiate between a generalist and a specialist, and

Whereas, the resolution did not specify reasons for the differentiation other than Title 18 and 19 of Public Law 89-97 which did not clearly differentiate them, and

Whereas, MSMS has always believed in the concept that an equal fee be provided for an equal service, and

Whereas, it is not possible for an agent or agents to differentiate between the value of services rendered by a particular physician when such services are of equal value to the patient, and

Whereas, to differentiate the quality of medical care through the age of a physician or by criteria as set forth by others is a form of discrimination not based on ability, and

Whereas, the practice of medicine is a sacred profession, the value of which can only be judged by the patient, and the ability of the practitioner can be judged only by his fellow physicians within a medical community, therefore be it

RESOLVED: That the House of Delegates rescind Resolution 22 of the 1966 House of Delegates.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, stated:

"Here again we are faced with the reality that specialty designation is necessary. Since this is so, the Reference Committee concludes that it would be in the best interest of our Society to have a definition developed by this House rather than to rely on the classical definition by "board certification only", which is much more restrictive.

"The definition was arrived at by prolonged hearings of this House in 1966. This was referred to The Council, who held special hearings, after which the definition was reaffirmed in July 1967 as a practical and reasonable definition of a specialist. No new evidence was forthcoming at our Reference Committee hearings that was considered an improvement on this definition. The Reference Committee recommends that Resolution 5 be disapproved."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 6

William Beaumont Commemorative Postage Stamp
Introduced by Luther R. Leader, MD

Whereas, the first great American physiologist, William Beaumont, MD, conducted his experiments on human digestion while post surgeon at the fort on Mackinac Island, Michigan, which led to his international acclaim for scientific achievement, and

Whereas, William Beaumont, MD, is universally regarded as one of the great men of American medicine in recognition of his outstanding contribution to knowledge and in tribute to his memory the physicians of the State of Michigan in 1954 presented to the people of Michigan the Beaumont Museum on Mackinac Island, which has rightfully been called "the country's most significant medical shrine," and

Whereas, the "Mackinac Island Miracle", which brought Dr. Beaumont, the scientist, together with the opportunity for research which has exerted a profound influence upon generations of medical thought, took place in 1822, one hundred and forty five years ago, and

Whereas, the medical societies of Connecticut (where Dr. Beaumont was born), Vermont (where he was first licensed to practice medicine), Wisconsin (where he continued his research begun in our state), and Missouri (where he was buried) are jointly engaged in an effort to appropriately further honor the name and memory of William Beaumont, MD, therefore be it

RESOLVED: That the Michigan State Medical Society, in concert with other states, petition the Postmaster General of the United States to issue a commemorative postage stamp honoring William Beaumont, MD, on the 150th Anniversary (1822-1972) of "The Mackinac Island Miracle."

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 7

Number of Terms for MSMS Councilors
ntroduced by D. Bonta Hiscoe, MD

Whereas, it is standard procedure in many organizaions to provide for orderly turnover of its officers, and

Whereas, new ideas are needed in the leadership ranks of medicine, particularly in these times, and

Whereas, the Michigan State Medical Society's Constituion doesn't set any limit to the time a man can stay on The Council of the organization, therefore be it

RESOLVED: That the Bylaws be revised to specify hat Michigan State Medical Society Councilors have terms of three years; that Michigan State Medical Society Councilors may not serve more than three consecutive terms; that the same individual may return after an absence of at least one year.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of the resolution.

THE HOUSE did not adopt the report of the Reference Committee and did approve the resolution.

THE REFERENCE COMMITTEE subsequently presented on first reading the following proposed Bylaws changes: Add to Chapter 13, Section 1, the following sentence, "Councilors may not serve more than three consecutive terms; the same individual may serve additional terms after an absence of at least one year."

THE HOUSE, on second reading, adopted the proposed Bylaws changes.

RESOLUTION 8

Physical Medicine
Introduced by Harry A. Towsley, MD

Whereas, the practice of physical medicine is expanding throughout the State of Michigan, and

Whereas, many of the major cities in the State have practitioners in this specialty, and

Whereas, there would be value in the interchange of ideas and knowledge between the field of physical medicine and rehabilitation and other fields of medicine in Michigan, and

Whereas, this can be best accomplished in meetings such as those of the Michigan State Medical Society, therefore be it

RESOLVED: That a Section on Physical Medicine be established in the Michigan State Medical Society, and that Chapter 14, Section 1 of the Bylaws be changed to include the words "Physical Medicine."

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of the resolution.

THE HOUSE did not adopt the report of the Reference Committee and did approve the resolution.

THE REFERENCE COMMITTEE subsequently presented on first reading the following proposed Bylaws changes: In Chapter 14, Section 1, insert the words "Physical Medicine" between the words "Pediatrics" and "Plastic Surgery".

THE HOUSE, on second reading, adopted the proposed Bylaws changes.

RESOLUTION 9

Medical Advisors to Michigan Partners of the Alliance
Introduced by Edwin H. Terwilliger, MD

Whereas, the former Crown Colony of British Honduras is in the stage of achieving full independence, and is to be known as Belize, and

Whereas, Belize is in an underdeveloped condition in all phases, one of which includes the field of medicine, and Belize is actively seeking help in all fields of endeavor, and

Whereas, investigation of the medical status of Belize reveals that for a population of 110,000, spread over an area of 8900 square miles, with over half of the population in six urban areas, with a physician population of 22, or an MD population ratio of 1 to 5,000; a dental population of 6, a dental ratio of 1 to 18,000 with 304 hospital beds, or 360 persons per bed, and

Whereas, the State of Michigan has formally adopted a program of active cooperation with the Country of Belize, the name of which program is the Michigan Partners of the Alliance, a non-profit corporation, incorporated in the State of Michigan, and

Whereas, the Nation of Belize is in urgent need of guidance in the previously mentioned field of medical care, in all its aspects, therefore be it

RESOLVED: That the Michigan State Medical Society take official recognition of the medical needs of Belize, and be it further

RESOLVED: That the House of Delegates of the Michigan State Medical Society cause a committee to be created and offered as advisors on medical and medical education matters to the Michigan Partners of the Alliance, and to its Committee on Public Health and Medical Education.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, approved in principle the voluntary group action in all areas of humanitarian endeavors, but felt State Society involvement would create a burden with many similar proposals by organizations seeking endorsement. Therefore, the Reference Committee recommended disapproval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 10

Board of Pharmacy Rules & Regulations R 338.486-16 (c)
Introduced by Harold L. Oster, MD

Whereas, in the Board of Pharmacy Rules and Regulations, R 338.486-16 (c) it has been the intention of the Michigan State Pharmaceutical Association and the M.S.H.P. to provide a reasonable degree of safety by "reducing as much as possible medication errors that were occurring in hospitals as a result of unqualified personnel dispensing drugs: Providing for interpretation of all medication orders by registered pharmacists in every possible instance in order to reduce errors," and

Whereas, these very laudable intentions of providing a reasonable degree of patient safety have not been fulfilled in that errors in medication have been increased, orders have been missed, confusion has reigned supreme, and the paper work load for physicians has doubled, and

Whereas, evidence of this confusion may be easily noted by observing the number of different types of forms which have been devised to meet the regulation 338.486-16 (c), therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society request the Michigan State Board of Pharmacy to re-evaluate and rescind this paragraph from the administrative code relating to pharmacy.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended that The Council refer this resolution to MSMS Liaison Committee with the Michigan State Pharmaceutical Association for further study and report back to the 1968 House.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 11

Guidelines on Utilization
Introduced by R. H. Hamburg, MD

Whereas, the Michigan State Medical Society should provide leadership and assistance to the membership in developing sound utilization programs, and

Whereas, the Principles on Utilization adopted by The Council of the Michigan State Medical Society establish basic guidelines applicable to all areas, therefore be it

RESOLVED: That the House of Delegates approve the following statement titled "Principles on Utilization":

Introduction:

Proper utilization involves optimum use of community medical resources, i.e., medical personnel (doctors, nurses and paramedical people), hospital, extended care, and laboratory facilities. Thus utilization is concerned with the over-all conservation of community health resources so that each individual can be accorded the best available quality of medical care. It is apparent from this statement that uniform standards cannot be applied to all communities and that medical utilization requirements may vary within the same community dependent upon demand for and availability of service. For purpose of clarification, it should be noted that medical audit, on the other hand, is concerned with the quality of medical care as provided for the individual.

Utilization involves the evaluation of medical services and final decisions must be based on medical judgment. Therefore utilization control programs must be directed by physicians. As stated above, variations in medical practices and availability of medical resources make it mandatory that guidelines and criteria be developed locally and applied to that community.

I. The Role of the County Medical Society:

A. Development of Utilization Programs:

It is the responsibility and prerogative of the county medical society, the official organization of physicians in an area, to provide leadership in developing effective and proper utilization programs. The medical society shall (1) promulgate principles and policies for the development and operation of utilization plans, (2) offer advisory and consultative services to physicians and all groups having a valid interest in utilization, (3) serve as a repository of information on utilization principles, programs, policies and mechanisms developed as ,tools in evaluating medical services, (such information is now available from diverse sources, i.e., the medical literature, statistical studies by insurance carriers and the excellent studies of the Professional Activities Survey), and (4) accept appealed cases and establish mechanisms for adjudication of such cases.

The services of the medical society shall be available to physicians, hospital administrators, directors of extended care facilities, insurance companies, governmental agencies and other groups with valid interests in utilization. The medical society shall publicize these services through its official organ, through its liaison relationship with health and governmental agencies, and through all other community media reaching both the profession and the public.

To carry out these responsibilities the county society shall establish a standing committee on utilization with representatives from all major specialties and various geographical areas with a maximum of 12 voting members. It shall have experts in affiliated fields, i.e., hospital administrators, computer experts, insurance consultants, etc. available as advisors. The primary function of this committee shall be to advise the society, physicians, health institutions and other agencies on problems concerning utilization when requested. To become knowledgeable in this field, and as a basis for establishing policy, the committee shall (a) collect available utilization information and (b) develop criteria to evaluate adequately the frequency of use of medical services. This would involve community data as a whole and should be available to the committee and its physicians. The establishment of guidelines and standards of practice, i.e., based on specific diagnosis, length of stay, appropriateness of laboratory studies, and evaluation of management should not be formulated by county or state societies. Such functions should be carried out by Hospital Utilization and/or Audit Committees.

B. A Claims Review Function:

A claims review committee will consider individual cases by written request submitted by physicians or by them on behalf of hospitals, extended care facilities, prepayment and health insurance organizations, voluntary and governmental agencies or any other organization with appropriate interest in securing and financing health services. The committee's responsibilities shall be those of adjudication and negotiation and its long range purpose should include educational processes designed to improve the understanding of proper use of coverage and services. It shall not be vested with disciplinary authority. If investigation indicates a need for disciplinary procedures, the complete report should be referred to the Ethics Committee.

II. Hospital Utilization Committees:

Hospital utilization committees should concern themselves with assay of proper utilization by the hospital staff of the hospital facility and with education of the staff as to these principles. There also is a need for this committee to serve as a claims review committee. These functions should be designed and understood as separate functions of this committee. The committee should concern itself with (1) the review of admissions and justification of need, (2) the review of all instances of prolonged hospital stay, (3) employ statistical methods to identify physicians who regularly have prolonged stay patients and submit their practices to audit. This implies the use of data so adduced to permit correction by education where over-utilization exists. (4) Study various diagnostic categories to establish average practices within the hospital.

Hospitals which are too small to form an effective utilization committee from their own staff may employ outside physicians to serve on such committees. Costs incurred are reimbursable to the hospital under the Medicare Law. It is ethical for the physician rendering this service to establish a fair fee for the use of his time.

III. Utilization in Extended Care Facilities:

A distinct difference between nursing homes and extended care facilities should be recognized. An extended care facility, as defined under Medicare, is an institution or a distinct part thereof which has entered into a transfer agreement with a hospital to provide services for the eligible patient. Section 405.1137 of PL 89.97 delineates the requirements which an extended care facility must meet in order to participate and outlines various procedures for meeting these requirements. The law also provides that costs incurred in connection with implementation of utilization or review principles are included as reasonable costs and are reimbursable. Therefore, physicians who serve on a utilization committee of an extended care facility are entitled to payment for such services. It is acceptable and ethical for doctors to enter into contracts with extended care facilities to serve on utilization committees for a fee. The amount of the fee is to be determined between the physician and the institution.

IV. Utilization for Doctors' Offices:

Determination of utilization in a doctor's office must perforce be on an individual basis.

Physicians, insurance carriers, and governmental agencies are invited to seek the advice of the society's standing committee on utilization in evaluating questions of principle. If a difference of opinion cannot be resolved by negotiation between a physician and a third party, either the physician or the agency may refer the case to the county society for consideration. Such cases shall be referred to the Claims Review Committee.

The society will also accept cases from patients but these shall be processed by the Mediation Committee in accordance with established policy.
The principle of control of care within a doctor's office rests within the code of professional ethics. The Claims Review Committee may refer cases of mis-utilization to the Ethics Committee.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recognized that Resolution 11 serves as an additional example of a means of measurement of utilization which might be considered when developing guidelines of utilization at the local county medical society level.

In recognition of the fact that situations governing the deliverance of medical service vary in different geographical sections of the State, the Reference Committee recommended that Resolution 11 be disapproved. It was suggested that county societies might develop their own guidelines for delivery of medical services.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 12

Hospital Utilization Review Manual
Introduced by Donald N. Sweeny, Jr.

Whereas, the Committee on Evaluation of Prepaid Medical Services has resubmitted its Hospital Utilization Review Manual for consideration, and

Whereas, the Minority Report of this Committee explains clearly why this Manual should not be officially adopted and submits a series of recommendations, therefore be it

RESOLVED: That the House of Delegates go on record in support of the Minority Report of the Committee on Evaluation of Prepaid Medical Services.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended no action on this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 13

Single Medical Practice Act
Introduced by Arthur B. Levant, MD

Whereas, the MSMS House of Delegates has urged the passage of a single medical practice act in Michigan on numerous occasions, and

Whereas, such a single medical practice act ought to be enacted for the benefit of the people of Michigan, and

Whereas, to date The Council of the Michigan State Medical Society has not been effective in obtaining such an act, therefore be it

RESOLVED: That this House of Delegates instruct The Council of MSMS to prepare, and to request introduction in the next session of the Michigan Legislature, a bill to establish a single medical practice act and vigorously seek legislative support for the passage of such an act.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, amended the resolution to read:

"Whereas, the House of Delegates of MSMS has urged the passage of a single Medical Practice Act; therefore, be it

"RESOLVED: That this House of Delegates instruct The Council of MSMS to prepare for introduction to the Michigan Legislature a bill to establish a single Medical Practice Act and to return it to the next Session of this House of Delegates."

THE REFERENCE COMMITTEE recommended adoption of the Resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 14

Joint Committee with State Bar of Michigan to Study the Problem of Malpractice Suits
Introduced by John G. Slerun, MD

Whereas, there has been reported to be a marked increase in malpractice suits in Michigan in recent years, and

Whereas, many such suits lack merit, and

Whereas, a review of various plans used throughout the country to reduce the number of such cases indicates many have serious flaws and seem unacceptable in their present format for use by component county medical societies in Michigan, and

Whereas, it is urgently necessary that some acceptable solution be found to lessen the ever increasing threat to physicians of malpractice claims without merit, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society request the State Bar of Michigan to organize with the Michigan State Medical Society a joint study commission to seek a workable solution, such as a joint arbitration committee of physicians and lawyers to lessen the number of unsubstantiated claims, and be it further

RESOLVED: That the joint commission be requested to report its findings and recommendations to both the State Bar of Michigan and the Michigan State Medical Society at the earliest practicable date, but not later than September, 1969.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, at the request of the author, deleted the words, "such as a joint arbitration committee of physicians and lawyers" from the first Resolved, leaving the two Resolveds to read:

"RESOLVED: That the House of Delegates of the Michigan State Medical Society request the State Bar of Michigan to organize with the Michigan State Medical Society a joint study commission to seek a workable solution to lessen the number of unsubstantiated claims; and be it further

"RESOLVED: That the joint commission be requested to report its findings and recommendations to both the State Bar of Michigan and the Michigan State Medical Society at the earliest practicable date, but not later than September 1969."

THE REFERENCE COMMITTEE approved in principle that a method should be sought to decrease the number of malpractice suits in Michigan, and recommends that this resolution be referred to The Council's Liaison Committee with the State Bar of Michigan to study the feasibility of establishing such a commission and to report to the 1968 House of Delegates.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 15

Utilization Control
Introduced by Carl H. Birkelo, MD

Whereas, the medical profession has primary interest and responsibility for matters affecting the utilization of health services, and

Whereas, the 1964 and 1965 House of Delegates agreed philosophically to consider such matters, and

Whereas, Medicare and similar laws establish a multilateral involvement, especially requiring activities by carriers and intermediaries, therefore be it

RESOLVED: That the Michigan State Medical Society establish an appropriate House of Delegates committee to give direction and leadership on the question of utilization review and, also, to serve as a liaison mechanism with such organizations as Michigan Blue Shield on such matters.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended no action on this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 16

Utilization Control
Introduced by Bruce D. Bauer, MD

Whereas, the Michigan Society of Internal Medicine observes the September, 1966, action of the Michigan State Medical Society House of Delegates to cease publication and withdraw support of the Hospital Utilization Review Manual, a product of the House of Delegates Committee on Evaluation of Prepaid Medical Services, and

Whereas, many members of the Michigan Society of Internal Medicine took an active part in the development of this Manual and highly approve of the methodology and content of the Manual, and

Whereas, MSIM feels that MSMS, and consequently organized medicine, has lost considerable initiative in the field of quality control of medical care, and

Whereas, the need for the expression of professional responsibility in quality medical control is the proper motivation for implementation of such measures, we must not neglect to observe that the interests of third parties, including government and the general public, will dictate some other form of control of hospital utilization (for example, a statistical review of length of stay and number of services as a substitute for quality control of medical practice), therefore be it

RESOLVED: That the Michigan State Medical Society reconsider the action of the House of Delegates of 1966 and reaffirm the enthusiastic support, publication and distribution of the Manual for the guidance of medical staff organizations in the responsible discharge of quality medical care in Michigan hospitals.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended no action on this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 17

Financial Remuneration for MSMS Officers
Introduced by Richard R. Galpin, MD

Whereas, the responsibilities of Michigan State Medical Society officers are becoming increasingly more complex and time-consuming, and

Whereas, the discharge of said responsibilities require significant and increasing amounts of time for said officers, therefore be it

RESOLVED: That the Finance Committee of The Council investigate the concept of adequate financial remuneration for said officers, and be it further

RESOLVED: That said committee investigate suitable means of securing the additional monies required, and be it further

RESOLVED: That the report and recommendation of said committee be given to the Annual Session of the House of Delegates in 1968.

THE REFERENCE COMMITTEE on Ways and Means, S. N. Kelso, MD, recommended "adoption of the resolution without any implication of approval or disapproval of the principle of remuneration of officers of MSMS".

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 18

Medical Research Institute
Introduced by Edward E. Elder, Jr., MD

Whereas, there is a need for factual data on medicine today, and

Whereas, such factual data are being accumulated in industry, labor, unions, universities and government, and

Whereas, a definite work sheet has been presented to this body through the publication, "Where We Stand," therefore be it

RESOLVED: That the Michigan State Medical Society House of Delegates endorse the principles of an independent research institute as outlined in the above-named publication.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, amended the third Whereas, to read, "Whereas, a definite work sheet has been presented to this body through the publication, 'Where We Stand', and in supplement publication 'Health Information Research Institute', therefore be it".

The Committee added a last Resolved to read,

"Be it further

RESOLVED: That The Council be authorized to provide for organizational expenses incidental to incorporation of the Institute, the materials necessary to present the principles of the Institute to prospective sponsors, and such seed money as The Council deems necessary and available within the limitation of its present over-all budget."

The Committee then recommended adoption of the Resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 19

Hospital Utilization Review Manual
Introduced by John H. McLaughlin, MD

Whereas, the proposed endorsement and publication of the Hospital Utilization Review Manual by the Michigan State Medical Society raised serious questions concerning development of new standards of medical practice during discussions of this Manual at the 1966 meeting of the House of Delegates, and

Whereas, the Manual, which is submitted for endorsement and publication, is not significantly altered to eliminate these serious questions concerning standards of medical practice, and

Whereas, it is the opinion of legal counsel for MSMS that such endorsement and publication will likely result in establishment of these aforementioned standards despite statements to the contrary as expressed in the Manual, and

Whereas, it should not be a function of a utilization review manual to establish standards of medical practice, therefore be it

RESOLVED: That the Michigan State Medical Society withhold endorsement and publication of the Hospital Utilization Review Manual, and be it further

RESOLVED: That the Hospital Utilization Review Manual be resubmitted to an appropriate committee of the Michigan State Medical Society for further attempts at modifications which will remove the likelihood of development of standards of medical practice.

THE REFERENCE COMMITTEE on Reports of Standing

and Special Committees, H. A. Towsley, MD, Chairman, recommended no action on this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 20

Physician Responsibility for Physical and Occupational Therapies

Introduced by Victor A. Notier, MD

Whereas, the medical profession realizes that all forms of treatment provided by paramedical personnel should be under the direction of, and ordered by, a physician, and

Whereas, under Public Law 89-97, and Title XIX, physical and occupational therapies may be carried out at extended care facilities, therefore be it

RESOLVED: That Michigan Hospital Service, as the carrier for Public Law 89-97 and Title XIX in the State of Michigan, require specific instructions from the attending physician, after proper examination of the patient, as to the type, amount, and duration of such therapies as may be needed, and that the physician be reimbursed for such examination, prescription, and supervision.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, amended the first part of the Resolved to read: "That the carrier and the fiscal agent for Public Law 89-97 and Title XIX in the State of Michigan. . . ", and recommended adoption of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 21

Chiropractic

Introduced by Kornelius Van Goor, MD

Whereas, the practice of chiropractic in the State of Michigan has reached considerable proportions and impact, and

Whereas, the Association of Chiropractic during the last legislative session as well as many previous sessions has made serious and determined efforts to increase its area of practice, and

Whereas, continued and renewed vigorous efforts are being employed to bring about revisions in the laws of the State of Michigan during the next Legislature favorable to chiropractic, and

Whereas, the American Medical Association at the 1966 National Congress of Medical Quackery issued the statement that chiropractic represents an unscientific cult, and

Whereas, physicians have an obligation to promote the science and art of medicine and the betterment of public health and that they should be more aggressive in educating the public as to the falsity of chiropractic claim, therefore be it

RESOLVED: That the Michigan State Medical Society establish a high quality educational program, based on common sense without enmity or malice, designed to enlighten the general public on the unscientific medical methods and the use of same by poorly trained practitioners of the chiropractic cult.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended adoption of the following Substitute Resolution: "That the MSMS encourage an educational program to enlighten the general public on the dangers of the use of unscientific methods by the chiropractic cult."

THE HOUSE amended the report of the Reference Committee and adopted the following amended Substitute Resolution: "That the MSMS be encouraged to initiate an educational program to enlighten the general public on the dangers of the use of unscientific methods by the chiropractic cult."

RESOLUTION 22

Study of Adequacy of Training of Certain Para-Medical Personnel

Introduced by Jack Hoogerhyde, MD

Whereas, the field of rehabilitative medicine is rapidly expanding, and
Whereas, programs of technical training are now being promoted in the field of physical therapy assistants, and

Whereas, the medical profession is ever cognizant of its responsibility for the safeguarding of the public health, therefore be it

RESOLVED: That Committee on Rehabilitation be empowered to study the adequacy of training, the practice procedures allowed, and limitations of responsibilities of such trainees, and be it further

RESOLVED: That the findings of such study, and recommendations for improvement or change of such courses, be reported to The Council, and that The Council initiate such action as may be required to safeguard the public health in this field.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended adoption of the resolution after amending the first Resolved to read:

"RESOLVED: That The Council's Committee on Rehabilitation, in conjunction with the Education Liaison Committee of The Council, be empowered to study the adequacy of training, the practice procedures allowed, and the limitations of responsibilities of such trainees, and be it further".

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 23

Recognition of the Board of Registration of Physical Therapists

Introduced by Harvey M. Andre, MD

Whereas, the establishment of standards, and the safeguarding of the procedures, of any and all therapy measures used on the acutely or chronically ill patients, is of utmost concern to the organized medical profession, and

Whereas, the 1966 House of Delegates of the Michigan State Medical Society supported Resolution 24 entitled, "Approval of Legislative Review of 'Healing Arts' Licensure and Practice Laws", and

Whereas, a Board of Registration of Physical Therapists has been established to effect standards for training and licensure of physical therapists in hospitals and extended care facilities, therefore be it

RESOLVED: That the Michigan State Medical Society recognize the Board of Registration of Physical Therapists of the State of Michigan as the duly constituted agency determining the qualifications of those bearing the title 'Physical Therapist'.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, amended the resolution by striking the Resolved and substituting the following:

"Whereas, the Michigan State Board of Registration of Physical Therapists is the duly constituted agency determining the qualifications of those bearing the title 'Physical Therapist'; therefore, be it

"RESOLVED: That physicians of Michigan should use the most highly qualified physical therapists available; and be it further

"RESOLVED: That the Committee on Rehabilitation be instructed to inform the members of the Michigan State Medical Society of the qualifications of the different groups of practicing physical therapists."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 24

AMA Delegation Chairman to Attend Council Meetings
Introduced by Luther R. Leader, MD

Whereas, the MSMS delegation to the American Medical Association has the responsibility of interpreting this Society's policies, and

Whereas, The Council in the interim between meetings of the House of Delegates executes the policies of this Society and therefore interprets them in practice, and

Whereas, communication with the MSMS Delegates to the AMA and vice versa could be enhanced by the Chairman of that delegation regularly sitting with The Council, and

Whereas, membership in The Council by the delegation Chairman might confuse his responsibilities and the lines of authority which in fact are directly from this House, therefore be it

RESOLVED: That this House of Delegates recommend to The Council that it invite to its meetings on a continuing basis, with expenses paid as for any member of The Council, the then current chairman of the MSMS Delegation to the American Medical Association House of Delegates.

THE REFERENCE COMMITTEE on Miscellaneous Business, M. Peebles-Meyers, MD, Chairman, deleted the fourth Whereas, and recommended adoption of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 25

Care of Handicapped Children
Introduced by Herbert W. Harris, MD

Whereas, the American Academy of Orthopaedic Surgeons has developed a Committee for the Care of the Handicapped Child, and, further, has developed a Michigan Ad Hoc Committee for the Care of the Handicapped Child, to maintain and indeed improve the care of the handicapped child, and

Whereas, the Michigan Orthopaedic Society has appointed the identical committee to serve as an Ad Hoc Committee for the Care of the Handicapped Child, and

Whereas, there is a possible threat to the maintenance of standards of care by the introduction of new and recent legislative acts, both federal and state, therefore be it

RESOLVED: That the Michigan State Medical Society approve and support this Michigan Ad Hoc Committee for the Care of the Handicapped Child in its efforts to maintain the high standards of care performed by doctors of medicine and to coordinate the work of both private and governmental agencies in the proper utilization of existing facilities.

THE REFERENCE COMMITTEE on Miscellaneous Business, M. Peebles-Meyers, MD, Chairman, approved the intent of Resolution 25 but recommended that no action be taken. The Reference Committee noted that this effort is in accord with the Reference Committee's recommendation that a new special committee of MSMS be formed for coordinating the care of the handicapped child. The Reference Committee recommended, therefore, that the Ad Hoc Committee of the American Academy of Orthopedic Surgeons channel its efforts through the MSMS.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTIONS 26 and 27 were withdrawn by the introducer.

RESOLUTION 28

Physician Involvement in Operation of Variable Fee Program
Introduced by Paul T. Lahti, MD

Whereas, Michigan Medical Service has moved to adopt a system of payment for professional medical services based on consideration of the individual physician's customary fee and its relationship to the prevailing range of fees, in accordance with an action of the 1966 House of Delegates, and

Whereas, the operation of this proposed variable fee system will not be a simple statistical exercise to be delegated wholly to technical management personnel but will require continual review and reassessment with consequent decisions as to policy at frequent intervals, and

Whereas, it is in the mutual interest of all parties to the prepayment method of financing medical care that physicians participate in and identify with the Blue Shield plan, therefore be it

RESOLVED: That authority and responsibility for continuing review and recommendation concerning the operation of the variable fee program be vested in the Medical Advisory Committee of Michigan Medical Service, acting in close liaison with local medical advisory boards designated by county medical societies, recognizing that all recommendations of the Medical Advisory Committee remain subject to approval or modification by the Board of Directors of Michigan Medical Service.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended no action on the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 29

Blue Shield Responsibility to House of Delegates
Introduced by Paul T. Lahti, MD

Whereas, the Michigan State Medical Society House of Delegates in considering the Novy Report of 1960 (the report of the Joint Committee of the Michigan State Medical Society and the National Blue Shield Association) passed the following resolution: "That any change in income ceiling or major change in scope of benefits in any insurance contract be submitted to this House of Delegates for appropriate action," and

Whereas, this action has not been rescinded since that time, therefore be it

RESOLVED: That the 1967 House of Delegates reaffirm this resolution: "That any change in income ceiling or major change in scope of benefits in any insurance contract be submitted to this House of Delegates for appropriate action."

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of Resolution 29 with the following comments:

"Resolution 29 resolves 'That the 1967 House of Delegates reaffirm this resolution (part of report of the Joint Committee of MSMS and National Blue Shield Plan, 1960) that any change in income ceiling or major change in scope of benefits in any insurance contract be submitted to this House of Delegates for appropriate action.' "

This resolution seems to have arisen in the wake of the recent development of the variable fee program. Rather extensive testimony revealed that not only has the plan been submitted to this House in the Annual Report of Michigan Medical Service, but that close contact with The Council at each monthly meeting has been the rule.

Also, meetings throughout the State for the purpose of exchanging information and ideas with as many physicians as possible were held. I would like to quote from the 1960 Novy Report the legal duties, responsibility and authority of the Board of Directors of Blue Shield:

"1 — To supervise and control the business, property affairs and management of Michigan Medical Service.

"2 — To make rules and regulations for the conduct of the affairs of Michigan Medical Service.

"3 — To determine scope of services to be furnished subscribers and conditions thereof; to adopt rates and fee schedules and enter into contracts with subscribers for provision for payment of all such services.

"4 — To revise, alter or amend the schedule of benefits and payments for services, in whole or in part."

I would also like to further quote recommendation No. 6 that appears on page 6 of the Novy Report, which states:

"That the operation of Michigan Medical Service be carried out by the Board of Directors, and that the Michigan State Medical Society and its committees be utilized in an advisory capacity when requested."

It is apparent to the Reference Committee that the Board of Directors of Blue Shield may carry on their business without submitting or referring the matters to this House of Delegates. We are certain that prudence has made a close relationship between the two bodies a mutually beneficial one. Since MSMS and its committees serve in an advisory capacity in relation to Blue Shield when requested, the connotation of the Resolved portion of the 1960 resolution is without validity. Therefore, we conclude it cannot be reaffirmed."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 30

Michigan Medical Service

Introduced by Harold L. Oster, MD

Whereas, The Council of the Michigan State Medical Society has been advised that the Board of Michigan Medical Service is at liberty to disregard any action of the Michigan State Medical Society, and

Whereas, Michigan Medical Service is offering health insurance which contracts for physicians' services on a service contract basis, and

Whereas, only physicians can render these services which are being offered by the Michigan Medical Service, therefore be it

RESOLVED: That Michigan Medical Service be instructed that no future service benefit contracts should be offered without prior approval of the Michigan State Medical Society, and be it further

RESOLVED: That, if Michigan Medical Service disregards this recommendation, the Michigan State Medical Society withdraw support from Michigan Medical Service and insist that Blue Shield no longer advertise itself as "The Doctors Program."

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 31

Supporting Appropriations for Four-Year Medical School at MSU

Introduced by Andrew D. Hunt, Jr., MD

Whereas, the MSMS House of Delegates repeatedly has supported the expansion of Michigan State University's two-year College of Human Medicine to a full Doctor of Medicine degree-granting program in medical education, and

Whereas, the House of Delegates in September 1966 respectfully requested the State Board of Education to approve Michigan State University's request that it be authorized to proceed to the addition of the clinical years of medical education, and

Whereas, the State Board of Education in January, 1967, after receiving a thorough report from its specially designated Citizens' Committee on Education for Health Care, and in recognition of the mandatory nature of a university as the site for medical education, did approve Michigan State University's request that it be authorized to proceed to granting the degree of Doctor of Medicine, and

Whereas, the State Board of Education subsequently recommended to the Governor of Michigan and the Michigan Legislature that specific fiscal appropriations be enacted to implement expansion of Michigan State University's two-year College of Human Medicine to a full degree-granting medical college, and

Whereas, budgetary decisions had been finalized prior to the State Board of Education's recommendation, thereby precluding action by the Governor and the Legislature in the 1967 regular session, and

Whereas, the shortage of physicians and allied health personnel becomes ever more serious in the State of Michigan, and

Whereas, the implementation of a full medical college, with appropriate clinical facilities, can do much to alleviate the shortage, not only of physicians but also of other health personnel, such as registered and practical nurses, audiologists, X-ray technicians, etc., therefore be it

RESOLVED: That the Governor of the State of Michigan and the Michigan State Legislature be respectfully requested to make the appropriation recommended by the State Board of Education at the earliest possible date to enable Michigan State University to proceed immediately with the expansion of the two-year College of Human Medicine to a complete college of medicine granting the degree of Doctor of Medicine.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 32

Participation in Michigan Medical Service

Introduced by J. C. Danforth, Jr., MD

Whereas, Michigan Medical Service has authorized the continuation of individual case participation only on a temporary basis and thereafter may require participation by list, and

Whereas, limitation of participation by list will result in a low rate of participation, therefore be it

RESOLVED: That the House of Delegates recommend to the Board of Directors of Michigan Medical Service that the right of individual case participation be included without restriction in all new contracts.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended approval of the resolution, noting that Michigan Medical Service intends to review this matter in nine months but has not indicated that it necessarily will change this feature. Participation by individual case has been allowed for some time, is allowed presently, and probably will continue to be

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 33

Blue Shield "Action Line" for Medicare-Medicaid Cases

Introduced by Louis E. Heideman, MD

Whereas, the Medicare and Medicaid programs have not only increased the patient load of physicians but have greatly multiplied their billing and clerical work, and

Whereas, physicians now must spend considerable time and effort in reviewing with lay personnel questions that arise under these programs; and

Whereas, it is in the best interest of all people in Michigan that physicians be free to devote their maximum time and efforts to patient care, and

Whereas, considerable time is currently lost in attempting to obtain answers to pertinent questions, therefore be it

RESOLVED: That the MSMS House of Delegates recommend that the Board of Directors of Michigan Medical Service establish a better mechanism than is now present to resolve promptly questions from doctors concerning Medicare and Medicaid cases.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 34

Responsibilities of MSMS President
Introduced by C. J. France, MD

Whereas, the Bylaws of the Michigan State Medical Society stipulate that the President "shall be the general executive officer of the Society", and

Whereas, The Council, the executive body of the Michigan State Medical Society, elects its own chairman, and

Whereas, the President is only an ex-officio member of The Council with the right to vote and has the right to speak but not to vote in the House of Delegates, the policy-making body of the Society, and

Whereas, an organization must have strong leadership to be effective, and

Whereas, the present restrictions on the rights of the President make it impossible for the President to carry out his obligation as executive officer, and

Whereas, the President is elected by the House of Delegates, which is the duly elected representative of the membership, therefore be it

RESOLVED: That the Committee on Constitution & Bylaws of this House be instructed to prepare amendments to vest the President with the necessary authority, including the chairmanship of The Council, to enable him to exercise his responsibilities as the executive officer of the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of the resolution and further recommended that an ad hoc committee of the House of Delegates be appointed to reevaluate the executive duties of the President.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 35

Approval of Screening Programs
Introduced by Frank B. Bicknell, MD

Whereas, it is the responsibility of the county medical society to keep its membership informed and advised about screening tests and other health programs within its area, and

Whereas, physician support and participation is essential for the success of any health program, and

Whereas, there are variations in the medical practices in the different geographical areas in the State, therefore be it

RESOLVED: That The Council of the Michigan State Medical Society limit its approval of screening programs to those previously approved by the county medical society or societies in which the program is to be carried out.

THE REFERENCE COMMITTEE on Miscellaneous Business, M. Peebles-Meyers, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 36

Proposed Blue Shield Benefits for Sterilization
Introduced by Clark B. Smith, MD

Whereas, Michigan Medical Service categorically denies surgical benefits for any sterilization procedure, and

Whereas, medical and surgical and obstetrical indications for sterilization do exist, and

Whereas, the medical and surgical benefits to be obtained from a program of "prepaid insurance" should not be limited in such a way as to deny an individual's right to arbitrarily limit the size of his family or his future fertility any more than it should deny him the right to arbitrarily have a disfiguring scar revised or a disfiguring wart removed, and

Whereas, the Michigan State Medical Society should not be publicly sponsoring and promoting a program of "prepaid health insurance" when such contracts are discriminatory, therefore be it

RESOLVED: That the Michigan State Medical Society transmit to Michigan Medical Service the Society's opposition to this capricious and discriminatory restriction, and be it further

RESOLVED: That the appropriate officers and members of the Michigan State Medical Society include in their consultations and deliberations with Michigan Medical Service an insistence that the restriction be eliminated.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 37

Honoring Physicians who have Served in Vietnam
Introduced by Philip K. Stevens, MD

Whereas, several Michigan physicians, at great personal sacrifice, have volunteered their services to the civilians of South Vietnam under the Volunteer Physicians for Vietnam program administered by the American Medical Association, and

Whereas, Alfred B. Swanson, MD, of Grand Rapids, pioneered in the establishment of this program, and

Whereas, our state and county medical societies are encouraging physicians to serve in Vietnam under this banner, therefore be it

RESOLVED: That Robert F. Baugh, MD, of Detroit, Edward S. Bear, MD, of Detroit, Hugh T. Caumartin, MD, of Saginaw, Lambertus Mulder, MD, of Muskegon, Hugh L. Sulfridge, MD, of Saginaw, Franklin W. Wade, MD, of Flint, Joseph A. Grady, MD, of Detroit, and A. J. Neerken, MD, of Kalamazoo (who is presently serving in Vietnam), be given the highest praise and commendation for their outstanding work in this valuable portion of the international health activity of the medical profession in Michigan.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 38

New Blue Shield Program, Deletion of Certain Benefits
Introduced by Carl Birkelo, MD

Whereas, a new fee and benefit program has been developed by Michigan Blue Shield, and

Whereas, this program changes the philosophy of Blue Shield in Michigan, and

Whereas, the practicing physicians or the House of

Delegates were not consulted nor informed of this change, nd

Whereas, inclusion of outpatient hospital visits, office visits, and costs of drugs as benefits will greatly increase the cost of coverage, therefore be it

RESOLVED: That the House of Delegates as the corporate body of Blue Shield instruct the Board of Directors f Blue Shield to delete from the new proposed fee and benefit program the following items of coverage: 1) outpatient hospital visits, 2) office visits, and 3) cost of drugs.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution since during the Committee's hearings, it was explained that these benefits are on a rider basis and also have a co-payment feature. They are not basic benefits, and are obtained as options at extra cost. These benefits are offered by many Blue Shield plans (actually twenty-five) and various commercial companies throughout the nation, and are not exactly new. It is necessary to offer these in competitive marketing.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 39

Medical Society Membership for Osteopathic Physicians

Introduced by J. M. Stack, MD

Whereas, the AMA and MSMS have determined that voluntary professional association between physicians for medicine and osteopathy is ethical, and

Whereas, many osteopathic physicians have been practicing in general medical hospitals for a number of years, and

Whereas, many of the osteopathic physicians have benefitted from their association with medical doctors and have expressed a desire to develop a closer professional relationship with medical societies, and

Whereas, some of these same osteopaths have withdrawn their membership from the Michigan Association of Osteopathic Physicians and Surgeons, Inc. because of professional and ethical consideration, and

Whereas, upon withdrawing from their society they are left without a spokesman, and

Whereas, in its June 1967 convention the AMA approved a resolution calling for the development of "a method whereby qualifications of osteopathic physicians who are willing to subscribe to the principles of medical ethics of the AMA and who express the wish to join a component (county) medical society may be evaluated in order to determine eligibility for internship and residency training in AMA-approved hospital programs without jeopardizing the hospital's accreditation status. (Resolution 3 (A-66) introduced by the Ohio Delegation), and

Whereas, the present Constitution and Bylaws of MSMS provide that a component society may elect as an associate member and person not a member of the medical profession but engaged in scientific or professional pursuits the principles and ethics of which are consonant with those of the society [Chapter 2, sec. 3 (a)], therefore be it

RESOLVED: That all component medical societies be informed that the provision exists for including osteopathic physicians as associate members of the county society, and be it further

RESOLVED: That all county societies be encouraged to offer associate membership to their local osteopathic physicians on an individual basis, and be it further

RESOLVED: That these associate members shall be allowed to attend and participate in the monthly meetings, scientific and educational programs, committee functions and other society activities, and be it further

RESOLVED: That, as provided in the Constitution and Bylaws, these osteopathic physician associate members of county societies may be elected associate members of the MSMS upon recommendation of a component society.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended approval of the resolution after changing the word "shall" to "may" in the third Resolved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 40

Revision of Michigan's Abortion Laws

Introduced by Jack M. Stack, MD

Whereas, criminal and self-induced abortion is one of our major public health problems in this state and nation, and

Whereas, complications of criminal and self-induced abortions are the leading cause of maternal death in Michigan, and

Whereas, the Michigan Legislature is presently considering changes in the present law regulating abortion in this state, and

Whereas, MSMS should offer guidance to the Legislature on this question, and

Whereas, in the June convention the AMA changed its 78-year-old position on abortion and advised state societies to determine their positions and work with their Legislature on this problem, and

Whereas, no other medical practice is regulated by the criminal statutes in this state, and

Whereas, many reputable physicians are presently performing therapeutic abortions in accreditated hospitals for indications other than "to save the life of the mother", and

Whereas, if the law is just, a woman who finds herself in what seems to be an insoluble situation will not be forced to seek help from criminal or unethical abortionists or subject herself to the dangers of self-induced abortion, but will be allowed to seek ethical medical help from her personal physician, therefore be it

RESOLVED: That MSMS re-emphasize the belief that the attempt to produce abortion on any woman by anyone other than a licensed physician is a serious crime and that the law should be strictly enforced in cases of criminal abortion, and be it further

RESOLVED: That MSMS advise the Legislature that abortions performed by licensed physicians in licensed or accreditated hospitals should not be regulated by the criminal code, and be it further

RESOLVED: That MSMS work toward the revision of the Michigan abortion laws following the guideline that abortions may be performed in a licensed hospital by a licensed physician upon the request of the patient, regulated only as are other serious medical problems by the medical profession itself.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, amended the resolution and recommended its adoption as amended.

"Whereas, criminal and self-induced abortion is a public health problem in this State and nation, and

"Whereas, complication of criminal and self-induced abortion are a leading cause of maternal death in Michigan, and

"Whereas, the Michigan Legislature is presently considering changes in the present law regulating abortion in this State, and

"Whereas, in the June convention the AMA changed its 78-year-old position on abortion and advised state societies to determine their positions and work with their legislatures on this problem, and

"Whereas, if the law is just, a woman who finds herself in what seems to be an insolvable situation will not be forced to seek help from criminal or unethical abortionists or subject herself to the dangers of self-induced abortion but will be allowed to seek ethical medical help from her personal physician; therefore, be it

"RESOLVED: That MSMS re-emphasize the belief that the attempt to produce abortion on any woman by anyone other than a licensed physician is a serious crime, and that the law should be strictly enforced in cases of criminal abortion; and be it further

"RESOLVED: That therapeutic abortions performed by licensed physicians in licensed or accredited hospitals should not be considered a criminal act; and be it further

"RESOLVED: That MSMS work toward the revision and liberalization of the Michigan abortion laws."

THE HOUSE adopted the report of the Reference Committee after amending it by changing the first and second Resolved portions to read:

"RESOLVED: That Michigan State Medical Society re-emphasize the fact that an improperly performed abortion under unsanitary conditions by an improperly trained operator is a serious crime, and that the law should be strictly enforced in cases of criminal abortion; and be it further

"RESOLVED: That therapeutic abortions performed by licensed physicians in licensed and accredited hospitals, and subject to the rules of the medical staff and of the hospital, should not be considered a criminal act."

The third Resolved would remain as it stands.

RESOLUTION 41

Inclusion of MDPAC in MSMS Dues Billing
Introduced by P. T. Lahti, MD

Whereas, MDPAC is a vital function of MSMS, and

Whereas, only a small percentage of the MSMS support MDPAC financially, therefore be it

RESOLVED: That MSMS include the $25 donation to MDPAC in its billing with a footnote stating that this portion is voluntary and not deductible.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, amended the resolution by adding the word "clearly" after the word "stating" in the Resolved portion, and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 42

Support of Concentration of Health Services in State Health Department
Introduced by L. E. Heideman, MD

Whereas, reorganization of the Department of Health, Education, and Welfare of the Federal Government with creation of a *Bureau* of Social and Rehabilitative Services with assignments including crippled children, rehabilitation, mental retardation and Medicaid to this service has occurred, and

Whereas, this will probably be reflected in administrative reorganization at the state level, and

Whereas, we in Michigan have had experience with organization of health services under both welfare and health divisions, and

Whereas, the concentration of health related services under health auspices has been the most effective and productive arrangement, therefore be it

RESOLVED: That The Council of MSMS make the most forceful presentation possible to the Governor of the State of Michigan recommending the retention of health-related activities within an independent Department of Health, and be it further

RESOLVED: That the Committees on Legal Affairs and on Public Health be instructed to take such actions as seem needed to support the concentration of health services within the Department of Health.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 43

Support of AMA Policies on Health Services
Introduced by L. E. Heideman, MD

Whereas, reorganization of the Department of Health, Education, and Welfare has occurred with creation of a *Bureau* of Social Rehabilitation Services charged with responsibilities including activities in the areas of children, rehabilitation, mental retardation and Medicaid, and

Whereas, experience has indicated the need for coordination of health activities, and

Whereas, this can most effectively be achieved when such programs are under health auspices rather than welfare, therefore be it

RESOLVED: That the Michigan State Medical Society delegates to the American Medical Association be instructed to introduce suitable resolutions at the Interim Meeting of the American Medical Association to express our concurrence in current American Medical Association policy in this regard and to undertake such additional activities as will assure its implementation.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, recommended no action on the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 44

Joint Billings of MDPAC Contribution with MSMS Dues Statement
Introduced by V. V. Bass, MD

Whereas, American Medical Association President Milford O. Rouse, MD, has called for 100% support of the American Medical Political Action Committee, and

Whereas, the American Medical Association House of Delegates at its last meeting emphasized the desirability of a common billing service provided by state and county societies, through which non-deductible contributions can be made to political action committees, and

Whereas, forty-four state medical associations are currently doing so, and

Whereas, this MSMS House of Delegates in Resolution 53, September 1965, directed that joint billing be initiated when legally feasible, therefore be it

RESOLVED: That this House of Delegates again emphasize to The Council of the Michigan State Medical Society its desire to implement Michigan State Medical Society House of Delegates Resolution 53, September, 1965, to include joint billing with the annual dues statement of the Michigan State Medical Society for the non-deductible contribution to the non-partisan but very active and effective MD Political Action Committee.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 45

Contracts for Physicians' Services
Introduced by F. P. Rhoades, MD

Whereas, the Principles of Medical Ethics state: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the ree and complete exercise of his medical judgment and kill or tend to cause a deterioration of the quality of medical care, and

Whereas, this ethical responsibility can only be exercised by each physician or on his behalf by his duly elect d medical representative, therefore be it

RESOLVED: That all contractual agreements with inurance carriers for services of physicians and agreements or fee schedules be subject to the approval of the MSMS House of Delegates, and be it further

RESOLVED: That Michigan Medical Service and all ther governmental and health agencies seeking the services of physicians in Michigan be notified of this policy, nd be it further

RESOLVED: That, when such contracts have been negotiated on behalf of the membership, each and every physician be promptly notified of the contract, the fee chedule and the billing procedures.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution because it would interfere with he rights and prerogatives of the individual physician.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 46

Medical Student Preceptorship Program
Introduced by J. A. Witter, MD

Whereas, exposure to the private and personal practice f medicine is deemed necessary for a complete medical ducation, and

Whereas, the students of the Schools of Medicine of he University of Michigan, Michigan State University, nd Wayne State University would benefit from a more nclusive and practical experience in personal and private nedicine, and

Whereas, present academic curricula provide inadequate ssociation with the economics and pattern of private practice, therefore be it

RESOLVED: That the Michigan State Medical Society n concert with the Student American Medical Association hapters of the State's medical schools establish a "Preceptorship Program", with the concurrence and cooperation of the respective medical schools, which will (1) send first, second and third year medical students to private physicians in the local community for "one day preceptorships" and (2) send fourth year medical students to private physicians in the local community for preceptorships that will hopefully last for a minimum of four weeks.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended approval of the resolution after amending the Resolved to read:

"RESOLVED: That the Michigan State Medical Society, in concert with the faculties of the three medical schools of Michigan and the Student American Medical Association Chapter of the State medical schools, establish a preceptorship program throughout the State."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 47

Local Responsibility for Health Programs
Introduced by Sidney E. Chapin, MD

Whereas, the local county medical society should be the central body from which all local health programs emanate, and

Whereas, all health programs, screening and otherwise, should not be carried out locally unless it is with the approval of the local county medical society, and

Whereas, it is desirable and necessary that all health programs have the direction and participation of the local physicians, therefore be it

RESOLVED: That the local county medical society is charged with the responsibility of establishing effective lines of communication with the local health department and the local chapters of all voluntary health organizations and agencies, and that these agencies be informed of this action by the local county medical society.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended approval of the resolution after amending it as follows:

The Reference Committee added "it be the policy of the MSMS that" after the first word of the Resolved, and the word "periodically" after the words "be informed" in the last portion of the Resolved, so that the Resolved reads:

"RESOLVED: That it be the policy of the MSMS that the local county medical society is charged with the responsibility of establishing effective lines of communication with the local health department and the local chapters of all voluntary health organizations and agencies, and that these agencies be informed periodically of this action by the local county medical society;"

And added a second Resolved:

"RESOLVED: That this action of the MSMS be transmitted as guidelines to the secretaries of each component medical society."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 48

Wayne State University Centennial
Introduced by Frank B. Walker, MD

Whereas, Wayne State University is now entering its centennial year, and

Whereas, the opening of the Detroit Medical College in 1868 represents the foundation upon which Wayne State University and its School of Medicine is basing its yearlong celebration, and

Whereas, currently three of the eight-member Board of Governors of Wayne State University are physicians and members of the Michigan State Medical Society, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society officially recognize this centennial and instruct the President of MSMS to present publicly to Wayne State University School of Medicine a suitable award at its centennial Alumni Day in May, 1968, in recognition of the many contributions and varied services given over the years by the students, alumni, and faculty of Wayne State University School of Medicine and its predecessors; and be it further

RESOLVED: That this centennial be brought to the attention of the AMA House of Delegates.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 49

Separate State Health Department
Introduced by Henry C. Scovill, MD

Whereas, the Michigan State Medical Society has supported the interest of official health agencies in organized community efforts to maintain and protect the health of the people through programs concerned primarily with:

1. Vital statistics
2. Public health education
3. Environmental health and sanitation
4. Prevention and control of communicable diseases
5. Industrial health hazards

6. Maintenance of public health laboratories
7. Promotion of maternal and child health programs and standards

and with medical care organized at the community level for special groups and individuals only as defined by law, and

Whereas, the Michigan State Medical Society was originally largely responsible for the establishment of the Michigan Department of Health as a vehicle for the development of such public health activities, and

Whereas, a committee of the State Legislature is studying the possible combination of the Michigan Department of Health with the State Department of Social Services (formerly the State Department of Social Welfare), and

Whereas, such a combination might well de-emphasize environmental health, vital statistics, contagious disease control, etc., and direct the major emphasis of public health activities toward government-influenced medical care in major areas, and

Whereas, any such state consolidation could seriously affect the fifteen-million-dollar locally directed and locally financed official public health agency programs, as well as those financed by private health agencies in a similar fashion, therefore be it

RESOLVED: That the Michigan State Medical Society House of Delegates reaffirm its support of a strong separate State Health Department dedicated to the principles described herein, and direct vigorous MSMS opposition toward any reorganization of the State Departments which could operate contrarywise.

THE REFERENCE COMMITTEE on State and Federal Resolutions, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 50 was withdrawn by the introducer.

RESOLUTION 51

Driver Capability and Re-Evaluation for Licensure

Introduced by R. A. Rasmussen, MD

Whereas, death or injury on our highways is a major health problem which is related to us daily in our news media, and

Whereas, a substantial number of these fatal and nonfatal accidents involve drivers who are physically or mentally incapable due to age or related infirmities, and

Whereas, many of these physical or mental incapacities are known to the physicians, thereby qualifying them to render important assistance in screening and re-evaluation of licensure, and

Whereas, the regular three-year licensure renewal does not properly protect the public against drivers rendered incapable of safe driving in the interim, and

Whereas, although the legal responsibility for licensure rests with the Secretary of State, a professional responsibility (and one which is recognized by the public) rests upon the physician to assist in eliminating this health menace, therefore be it

RESOLVED: That MSMS offer its services to the Legislature and the Secretary of State in an advisory capacity to assist them in the development of a means whereby a fair evaluation of driver capabilities may be accomplished permitting the restriction or withdrawal of driving privileges from those judged to be physically or mentally incapable due to the infirmities of aging, and be it further

RESOLVED: That any legislation or regulation developed for this purpose shall provide for appeal by the person whose license has been restricted or withdrawn, and be it further

RESOLVED: That the physician assisting with such evaluation be provided adequate and proper legal immunity from suit arising from such assistance.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution amended as follows:

"Whereas, death or injury on our highways is a major health problem which is related to us daily in our news media, and

"Whereas, a substantial number of these fatal and nonfatal accidents involve drivers who are physically or mentally incapable due to age or related infirmities, and

"Whereas, the regular three-year licensure renewal does not properly protect the public against drivers rendered incapable of safe driving in the interim, and

"Whereas, although the legal responsibility for licensure rests with the Secretary of State, a professional responsibility rests upon the physician to assist in eliminating this health menace, therefore be it

"RESOLVED: That MSMS offer its services to the Legislature and the Secretary of State in an advisory capacity to assist in the development of means whereby a fair evaluation of driver capabilities may be accomplished permitting the restriction or withdrawal of driving privileges from those judged to be physically or mentally incapable due to the infirmities of aging."

THE HOUSE amended the report of the Reference Committee by striking the last six words of the Resolution and placing a period after "incapable", and adopting the report as amended.

RESOLUTION 52

Physician Representation on Hospital Governing Boards

Introduced by B. E. Brush, MD

Whereas, problems of hospital management have become increasingly complex, and

Whereas, the complexities of hospital administration have great impact upon the private practice of medicine, and

Whereas, physicians should locally play a greater role in the planning of future trends in medical practice, therefore be it

RESOLVED: That hospital boards of trustees have adequate medical representatives elected by the hospital staff of said hospitals.

THE REFERENCE COMMITTEE on Miscellaneous Business, M. Peebles-Myers, MD, Chairman, recommended approval of the resolution.

THE HOUSE amended the report by placing a period after the word "representatives" in the Resolved, thereby deleting the phrase "elected by the hospital staff of said hospitals." and adopted the report as amended.

RESOLUTION 53

MSMS Support of 1968 Student American Medical Association National Meeting in Detroit

Introduced by Joseph A. Witter, MD

Whereas, the 1968 national convention of the Student American Medical Association will be held in the City of Detroit April 23-28, 1968, and

Whereas, this convention will be a chance for Michigan medicine to show itself off to the future physicians of this nation, therefore be it

RESOLVED: That MSMS offer a hearty welcome to the Student American Medical Association, and be it further

RESOLVED: That the House of Delegates instruct The Council and staff to extend all possible cooperation to this group for their 1968 convention, and be it further

RESOLVED: That MSMS also work with SAMA so that the various hospitals and Michigan medicine might exhibit their advantages and opportunities for training as well as practice to the more than 2,000 young physicians who attend this convention.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 54

MSMS Liaison with Students of Health Care Professions
Introduced by J. A. Witter, MD

Whereas, it is commendable for students of medicine to educate and involve themselves in the paramedical and social issues of the day as related to the health care field so as to broaden their concept of total patient care, therefore be it

RESOLVED: That the Michigan State Medical Society appoint a liaison committee with students of the health care professions in order to extend the availability of medical care.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 55

Anti-discrimination in the Michigan State Medical Society
Introduced by B. C. Payne, MD

Whereas, there are anti-discriminatory clauses in the Michigan State Constitution, the various programs of the Federal government and our educational institutions, and

Whereas, there have been no problems of discrimination on the basis of race, religion or ethnic origin in the county or the state medical organizations of Michigan, and

Whereas, there is no such anti-discriminatory clause in the Constitution and Bylaws of the Michigan State Medical Society, therefore be it

RESOLVED: That the Constitution and Bylaws, Chapter 3, Section 1 be amended to add: "However there shall be no discrimination on the basis of race, religion or ethnic origin."

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, amended the Resolved portion of the resolution and presented on first reading the following proposed Bylaws changes: "That the Constitution and Bylaws, Chapter 3, Section 1, be amended to read: 'There shall be no discrimination on the basis of race, religion, sex, or ethnic origin.'"

THE HOUSE, on second reading, adopted the proposed Bylaw changes.

RESOLUTION 56

Development of Physicians' Hospital Privilege Act
Introduced by B. E. Brush, MD

Whereas, the MSMS House of Delegates in 1966 passed Resolution 55, "Hospital Staff Privileges for all Ethical Licensed Physicians", and

Whereas, the AMA House of Delegates in 1966 unanimously passed Resolution 34 stating that "all doctors of medicine regardless of their field of practice be accorded hospital privileges commensurate with their training, experience, and demonstrated competence; and that in the public and professional interest every ethical licensed doctor of medicine who needs and desires them have staff privileges in at least one accredited, full facilty community hospital", and

Whereas, there must be legislation which defines the relationship between hospitals and the practicing physicians, therefore be it

RESOLVED: That the Michigan House of Delegates instruct the Legal Affairs Committee to study the feasibility of developing a Physicians' Hospital Privilege Act embodying the intent of AMA Resolution 34 and to report back to the 1968 Michigan House of Delegates.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, deleted the third Whereas and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 57

Creation of MSMS-Sponsored Academy of Medical History as a Division of the Historical Society of Michigan
Introduced by A. H. Whittaker, MD

Whereas, the Academy of Medical History of the Ohio Historical Society has increased greatly the interest in medical history, and

Whereas, the Academy has resulted in a close relationship between the Ohio Historical Society and the Ohio Medical Association, therefore be it

RESOLVED: That the MSMS Committee on Medical History be instructed to consider establishing some such cooperative academy or association and report the Committee's recommendations to the 1968 House of Delegates meeting.

THE REFERENCE COMMITTEE on Miscellaneous Business, M. Peebles-Meyers, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 58

Clarifying Michigan Law to Safeguard Privileged Character of Medical Records
Introduced by A. H. Whittaker, MD

Whereas, there was introduced in the proceedings of the 1966 MSMS House of Delegates, Resolution 43 instructing The MSMS Council to consult with the State Bar of Michigan concerning the common practice of attorneys of obtaining the case histories and medical records of patients, which are privileged communications, by means of a court subpoena, without the knowledge or consent of the patient or physicians, the records subpoenaed for use in the attorney's office without benefit of medical consultation or benefit of the protection of the court, and

Whereas, opinions of legal experts hold that such action is controlled by an opinion of the State Supreme Court which holds that such records are privileged communication and cannot be obtained for inspection or revealed to the public or any third party, and

Whereas, privileged communications in this country are established by state law and Michigan does have such a statute, as established by the State Supreme Court in the case of Bassil vs. the Ford Motor Company, July 9, 1936 (278 Mich. 173), therefore be it

RESOLVED: That MSMS actively work with the State Bar of Michigan and the Michigan Legislature to clarify and strengthen the Michigan laws and court rules with respect to safeguarding the privileged character of medical histories and medical records held by physicians and by hospitals.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 59

Appeal Mechanism for Unresolved Adjudication
Introduced by F. P. McQuillan

Whereas, adjudication of fee problems at the county level may be prejudicial to either the local physician or Michigan Medical Service, therefore be it

RESOLVED: That MSMS establish an appropriate *appeal* mechanism available to either Michigan Medical Service or the physician concerned in the situation of unresolved adjudication.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended no action on the resolution.

THE HOUSE disapproved the report of the Reference Committee and did adopt the resolution as introduced.

RESOLUTION 60

Acceptance of Osteopaths as Residents and Interns
Introduced by A. C. Gholz, MD

Whereas, MSMS is on record favoring the highest standards of medical practice in Michigan as necessary for the adequate protection of the citizenry, and

Whereas, the dichotomy of the doctors of medicine and the doctors of osteopathy does not serve to promote such high standards, therefore be it

RESOLVED: That this House of Delegates respectfully request medical schools in Michigan to devise a means whereby scholastic credit and recognition can be given to those osteopathic students who have a satisfactory scholastic record so that such students might be accepted in medical schools of Michigan at the level for which they are qualified, and be it further

RESOLVED: That The Council on Medical Education of the AMA and the MSMS be requested to develop a program of postgraduate training under proper supervision to accept as interns and residents, osteopathic graduates who have developed a certain proficiency in education and training.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended that the resolution be referred to the Education Liaison Committee for further action.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 61

Health Council's Silver Anniversary
Introduced by Sidney E. Chapin, MD

Whereas, the Michigan Health Council has embarked upon its Silver Anniversary celebration and as part of this event has developed the Health Careers Mobile, and in an all-out effort to acquaint more of Michigan's students with the opportunities in the health field; therefore, be it

RESOLVED: That the House of Delegates commend the Michigan Health Council for its past accomplishments and present program; and be it further

RESOLVED: That the House of Delegates express its thanks to the various foundations who contributed to the financial support of this important Health Careers Mobile project.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution.

RESOLUTION 62

Commendation of Retiring Director of Michigan Department of Public Health
Introduced by Robert J. Mason, MD

Whereas, Albert E. Heustis, MD, is retiring as Director of the Michigan Department of Public Health, and

Whereas, his able administration of the Department in association with local departments of public health has resulted in efficient and consistently valuable service to the people and the physicians of this State, and

Whereas, he had displayed concern and conscientious devotion for the health and welfare of our citizens, and

Whereas, this dedicated and professionally excellent service has earned him well-deserved national and state recognition; therefore be it

RESOLVED: That this House of Delegates does hereby recognize his distinguished and outstanding service to humanity and expresses to Doctor Heustis appreciation and gratitude; and be it further

RESOLVED: That a suitable copy of this resolution be presented to Doctor Heustis.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution by a rising vote.

RESOLUTION 63

Appreciation to Speaker Lightbody
Introduced by Paul T. Lahti, MD

Whereas, Dr. James J. Lightbody has served as Speaker of the House of Delegates longer than any previous Speaker, and

Whereas, Dr. Lightbody has served untiringly with tact, humor and precision, and

Whereas, this House of Delegates wishes to express its sincere appreciation; therefore, be it

RESOLVED: That the Vice Speaker instruct the present reference committee chairman to plan and to execute an appropriate method of recognition.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution unanimously by a rising vote.

RESOLUTION 64

Commendation to Vice-Speaker Hayes
Introduced by Richard R. Galpin, MD

Whereas, Louis F. Hayes, MD has served this House with diligence, perception and humor in the capacity of Vice Speaker, and

Whereas, Dr. Hayes will be retiring from this office at the end of this session; therefore, be it

RESOLVED: That the Michigan State Medical Society House of Delegates record with sincere respect and great pleasure his services in this capacity; and be it further

RESOLVED: That The Council of the Michigan State Medical Society be instructed to express the respect of this House of Delegates to Dr. Hayes in a suitable manner.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution unanimously by a rising vote.

SPECIAL MEMBERSHIPS

THE REFERENCE COMMITTEE on Special Memberships, Arthur B. Levant, MD, Chairman, recommended approval of the following special memberships as recommended by the component medical societies and certified by the Secretary of MSMS in accordance with the Bylaws revised in 1965:

Life Memberships

Chippewa County — Claire H. Clausen, MD

Dickinson-Iron County — Wm. H. Alexander, MD; Lionel E. Irvine, MD; William J. Kofmehl, MD

Genesee County — Myrton S. Chambers, MD; Robert F. Hague, MD; Arthur H. Kretchmar, MD

Gogebic County — Paul R. Lieberthal, MD

Ingham County — Theodore I. Bauer, MD; Earl W. Brubaker, MD; Earl I. Carr, MD; Lewis H. Darling, MD (deceased); George A. Sherman, MD; Franklin L. Troost, MD

Jackson County — Don F. Kudner, MD

Kent County — Walter J. Jaracz, MD; John Ten Have, MD

Lenawee County — C. Harold Heffron, MD

Monroe County — Robert T. Ewing, MD; Robert J. Williams, MD

North Central Counties — Stanley A. Stealy, MD

Oakland County — Frank J. Fitzpatrick, MD; Fred T. Reid, MD; Harold R. Roehm, MD; Harold A. St. John, MD; Palmer E. Sutton, MD

Ottawa County — William J. Moerdyk, MD; Otto Van Der Velde, MD

Sanilac County — Robert K. Hart, MD

Washtenaw County — Heinrich H. Handort, MD; William Schumacher, MD

Wayne County — Arthur G. Armstrong, MD; Joseph R. Barton, MD; Watson Beach, MD; Walter G. Bernard, MD; Arthur R. Bloom, MD; Andrew H. Bracken, MD; William A. Chipman, MD; James E. Croushore, MD; M. Raymond Collings, MD; Albert DeGroat, MD; Hugh L. Dill, MD; Mable Freeman, MD; I. H. Friedman, MD; Charles Gitlin, MD; Perry C. Gittins, MD; Ben F. Glowacki, MD; Angus F. Goetz, MD; Jose Guerrero, MD; Lawrence E. Heinrich, MD; Rose E. Herrold, MD; John P. Hubbard, MD; Verne G. Hunt, MD; Joseph A. Johnston, MD; Benjamin I. Johnstone, MD; Roy C. Kingswood, MD; David Kliger, MD; Clark F. Lemley, MD; Alexander W. Pietraezewski, MD; Benedetto Pugliesi,MD; Howard C. Rees, MD; William S. Reveno, MD; Lufti M. Sa'di, MD; Ernest L. Stefani, MD; Henry D. Stricker, MD; Edward M. Vardon, MD; V. O. Vasu, MD; Russell F. Weyher, MD; Max O. Wolfe, MD

Retired Memberships

Houghton County — Wilfred J. Rowell, MD

Ingham County — Goldie B. Corneliuson, MD

Kalamazoo County — Hugh Aach, MD

Kent County — Isla G. DePree, MD

Muskegon County — Helen S. Barnard, MD; Eugene W. Lange, MD

North Central Counties — Keith D. Coulter, MD

Saginaw County — Thomas E. Fleschner, MD

Washtenaw County — Wilson K. Brewer, MD; Edwin H. Place, MD

Wayne County — Walter S. Glazer, MD; Harold J. Kullman, MD; Raymond J. Laige, MD; Elmore C. Vonder Heide, MD

Associate Memberships

The lists of candidates for Associate Membership from Gratiot-Isabella-Clare, Washtenaw and Wayne Counties were reviewed. Since all candidates are eligible, no action is required by the House of Delegates inasmuch as they may become Associate Members of this Society upon application and certification by the secretaries of their component medical societies.

Military Memberships

The list of candidates for Military Membership from Wayne County was reviewed. Since all candidates are doctors of medicine, no action is required by the House of Delegates inasmuch as they may become Military Members of this Society upon application and certification by the secretary of their component medical society.

THE HOUSE adopted the report of the Reference Committee.

PRESENTATIONS AND AWARDS

CERTIFICATES OF COMMENDATION

Secretary Johnson presented the following Certificates of Commendation as authorized by the House of Delegates:

Frank J. Busch, MD, Saginaw —

"In recognition of his inspiring civic service in Saginaw for more than twenty-five years, especially with medical programs for children and the aged, and for the unselfish assistance he has given young doctors."

W. H. Huron, MD, Iron Mountain —

"In recognition of many years of constructive service as a member of the MSMS Council, as a member of the Michigan delegation to the American Medical Association, as a respected leader of medical activities in the Upper Peninsula, and in appreciation of twenty-five years of service on the Michigan Blue Shield Board and for his accomplishments in cancer education and control."

Frederick J. Margolis, MD, Kalamazoo —

"In recognition of his nationally known education film, 'Parent to Child About Sex', his outstanding service as director of the Audio-Visual Medical Unit at Wayne State University School of Medicine, and his valuable research in poison prevention in children and in fluorides."

David I. Sugar, MD, Detroit (this posthumous award was accepted by Mrs. David I. Sugar) —

"This award is given posthumously in recognition of the many years of outstanding medical statesmanship with the Wayne County Medical Society and his many contributions to the **Detroit Medical News** over a period of more than thirty years."

Raymond W. Waggoner, MD, Ann Arbor —

"In recognition of his distinguished career as a psychiatrist, as Chairman of the University of Michigan Medical School Department of Psychiatry since 1937, and also for leadership as President of the American College of Psychiatrists and American Association of Chairmen of Departments of Psychiatry."

Charles H. Wright, MD, Detroit —

"In recognition of his fine leadership as President of the African Medical Education Fund and the International Afro-American Museum Committee and for his service to the United States Department of State for special missions to survey medical facilities in Africa."

MICHIGAN'S OUTSTANDING PHYSICIAN

President Payne presented to Henry Cook, MD, Flint, the following award as Michigan's Outstanding Physician of 1967:

"In recognition of his outstanding career as a physician, his many years of dedicated public service, and in grateful appreciation of his numerous contributions to medical organizations.

"As a general practitioner Dr. Cook has served his community of Flint with devotion for more than half a century. As a member of the Flint Board of Education for several decades, and as its four-term President, Dr. Cook has helped shape the outstanding Flint educational program.

"As a delegate and Councilor for many years, Dr. Cook led the Michigan State Medical Society as President in 1937-38 with vision and courage.

"And above all, he has served his patients with ability, honesty and the Golden Rule in his heart."

FIFTY YEAR AWARDS

President Payne presented the Fifty Year Award to the following:

Ira M. Altshuler, MD, Oakland County
Domenico M. Annessa, MD, Wayne County
Alfred L. Arnold, Jr., MD, Shiawassee County
Myron G. Becker, MD, Gratiot-Isabella-Clare County
William C. Behen, MD, Ingham County
William L. Brosius, MD, Wayne County
Robin Buerki, MD, Wayne County
Benjamin G. Holtom, MD, Calhoun County
J. R. Jeffrey, MD, Calhoun County
Herbert I. Kallett, MD, Wayne County
William C. Kools, MD, Ottawa County
Harry Lieffers, MD, Kent County
Arthur W. Newitt, MD, Ingham County
Algernon A. Palmer, MD, Washtenaw County
C. W. Sellers, MD, Wayne County

Fifty Year Awards subsequently were presented to the following persons who were not able to be present:

Charles A. Behney, MD, Ingham County
Lloyd K. Babcock, MD, Wayne County
Isadore I. Bittker, MD, Wayne County
R. G. Brain, MD, Genesee County
William J. Butler, MD, Kent County
John M. Carter, MD, Wayne County
William R. Chynoweth, MD, Calhoun County
Leon B. Cowen, MD, Wayne County
Robert L. Cowen, MD, Wayne County
Howard P. Doub, MD, Wayne County
Arthur Erkfitz, MD, Macomb County
James W. Hawkins, MD, Wayne County
William E. Henderson, MD, Wayne County
William Kane, MD, Macomb County
Edward D. King, MD, Wayne County
William J. Kofmehl, MD, Dickinson-Iron County
J. Leonidas Leach, MD, Genesee County
Joseph S. Leszynski, MD, Wayne County
Maurice C. Loree, MD, Ingham County
John W. MacKenzie, MD, Wayne County
William T. McAlonan, MD, Wayne County
Miar J. McLaughlin, MD, Jackson County
Vasil P. Moisides, MD, Wayne County
Elmer C. Texter, MD, Wayne County
G. Douglas Treadgold, MD, St. Clair County
Roy D. Tupper, MD, Wayne County
T. P. VanderZalm, MD, Ingham County
Clarence E. Weaver, MD, Wayne County

SPECIAL AWARDS

The following AMA Certificates of Humanitarian Service were presented by AMA President-Elect Dwight L. Wilbur, MD, to Robert F. Baugh, MD, Detroit, and Franklin V. Wade, MD, Flint.

"In recognition of the meritorious service he performed for the medical profession, the United States Government, and the people of South Vietnam, by treating the ill and injured during his medical mission under the American Medical Association's Volunteer Physicians for Vietnam."

The following special award to recently retired MSMS Secretary Oliver B. McGillicuddy, MD, was presented by Speaker Lightbody:

"Presented by The Council of the Michigan State Medical Society to Oliver B. McGillicuddy, MD.

"In deep appreciation for his outstanding contributions to his profession and the public.

"As Councilor from the Second Council District of the Michigan State Medical Society and as Chairman of The Council.

"As President and as Secretary of the Michigan State Medical Society, his wise counsel has guided his profession.

"Dr. McGillicuddy has rendered continuing exemplary service as a physician and citizen in the city of Lansing for thirty-five years, and at the same time has given distinguished leadership to the Michigan State Medical Society — a remarkable achievement by a dedicated servant of his profession."

EMPLOYEE AWARDS

Council Chairman Mason presented the following employee awards as previously authorized by the House of Delegates:

Vada L. Davis—15 years of service
Mary K. Brewbaker—10 years of service
Ralph T. Wills—5 years of service

TRIBUTE TO DECEASED FORMER MEMBERS OF THE HOUSE OF DELEGATES

Secretary Johnson read the following names and the members of the House arose and stood in silent tribute to their memory:

Robert D. Scott, MD, Genesee County
Charles I. Herrington, MD, Huron County
Robert S. Breakey, MD, Ingham County
John N. Wenger, MD, Kent County
Hugh R. Moore, MD, Newaygo County
J. W. O'Neill, MD, Newaygo County
Cleon R. Gatley, MD, Oakland County
Ethan B. Cudney, MD, Oakland County
John S. Lambie, MD, Oakland County
Clarence E. Toshach, MD, Saginaw County
Joseph P. Markey, MD, Saginaw County
Clarence D. Selby, MD, St. Clair County
William P. Bope, MD, Van Buren County
Arthur H. Steele, MD, Van Buren County
Duncan Campbell, MD, Wayne County
Harold E. Clark, MD, Wayne County
Harold Henderson, MD, Wayne County
Charles E. Lemmon, MD, Wayne County
William L. Sherman, MD, Wayne County
Charles S. Kennedy, MD, Wayne County
Archer A. Claytor, MD, Saginaw County
Howard H. Cummings, MD, Washtenaw County
John M. Sheldon, MD, Washtenaw County

ELECTIONS

The following Officers and Councilors were elected:

President-Elect—James J. Lighthody, MD, Detroit

Speaker—James B. Blodgett, MD, Detroit

Vice-Speaker—Vernon V. Bass, MD, Saginaw

Councilors (3-year terms)—

1st District: Ralph R. Cooper, MD, Detroit
Don W. McLean, MD, Detroit
Robert K. Whiteley, MD, Detroit

4th District: Don Marshall, MD, Kalamazoo

5th District: John R. Pedden, MD, Grand Rapids

6th District: Harold H. Hiscock, MD, Flint

14th District: Harold F. Falls, MD, Ann Arbor

Delegates to the American Medical Association
(January 1, 1968, to December 31, 1969)

Otto K. Engelke, MD, Ann Arbor
John R. Heidenreich, MD, Daggett
Luther R. Leader, MD, Royal Oak
Robert E. Rice, MD, Greenville

Alternate Delegates to the American Medical Association
(January 1, 1968, to December 31, 1969)
(in order of seniority)

Paul T. Lahti, MD, Royal Oak
Harold A. Furlong, MD, Pontiac
John W. Moses, MD, Detroit
Bradley M. Harris, MD, Ypsilanti

DIRECTORY

1967 MSMS House of Delegates

RECORD OF ATTENDANCE

	Meetings					
	1st	2nd	3rd	4th	5th	6th
OFFICERS						
James J. Lightbody, MD, Detroit, Speaker	X	X	X	X	X	X
Louis F. Hayes, MD, Gaylord, Vice-Speaker	X	X	X	X	X	X
Luther R. Leader, MD, Royal Oak mmediate Past President	X	X	X	—	—	—
Kenneth H. Johnson, MD, Lansing, Secretary	X	X	X	X	X	X
DELEGATES						
ALLEGAN						
Gerald VanderVoord, MD, Wayland	X	X	X	X	X	X
ALPENA-ALCONA-PRESQUE ISLE						
John W. Bunting, MD, Alpena	X	X	X	X	X	X
BARRY						
Robert J. Huebner, MD, Hastings	X	—	—	—	—	—
BAY-ARENAC-IOSCO						
William G. Gamble, MD, Bay City	—	X	X	X	X	—
Robert C. Prophater, MD, Bay City	X	X	X	X	X	X
BERRIEN						
F. Alan Kennedy, MD, Benton Harbor	X	X	X	X	X	X
Frederick H. Lindenfeld, MD, Niles	X	X	X	X	X	—
BRANCH						
Robert M. Leitch, MD, Union City	X	X	X	—	—	X
CALHOUN						
Russell C. Rowan, MD, Abion	X	X	X	X	X	X
George R. Kelleher, MD, Battle Creek	X	—	X	X	—	X
Donald J. Pearson, MD, Battle Creek	—	—	X	X	X	X
CASS						
Henry V. Guzzo, MD, Dowagiac	—	—	—	—	—	—
CHIPPEWA-MACKINAC						
Donald D. Finlayson, MD, Sault Ste. Marie	X	X	X	X	X	X
CLINTON						
James M. Grost, MD, St. Johns	X	X	X	X	X	X
DELTA-SCHOOLCRAFT						
Merle E. Wehner, MD, Manistique	X	X	X	X	X	X
DICKINSON-IRON						
Donald T. Anderson, MD, Iron Mountain	X	X	X	X	X	X
EATON						
Clayton O. Willits, MD, Charlotte	X	X	X	X	X	X
GENESEE						
Philip K. Stevens, MD, Flint	X	X	X	X	X	X
H. Maxwell Golden, MD, Flint	X	X	X	X	—	X
Lawrence G. Bateman, MD, Flint	X	X	X	X	X	X
Clifford W. Colwell, MD, Flint	X	X	X	X	X	X
Ernest P. Griffin, Jr., MD, Flint	X	X	X	X	X	X
Franklin W. Baske, MD, Flint	X	X	X	X	X	X
Paul E. Schroeder, MD, Flint	X	X	X	X	X	X
GOGEBIC						
Rex R. Harrington, MD, Ironwood	X	X	X	X	X	X
GRAND TRAVERSE-LEELANAU-BENZIE						
Frank H. Powers, MD, Traverse City	X	X	X	X	X	X
Arthur F. Dundon, MD, Traverse City	X	X	X	X	X	X
GRATIOT-ISABELLA-CLARE						
Jack M. Stack, MD, Alma	X	X	X	X	X	X
HILLSDALE						
Clark B. Smith, MD, Hillsdale	X	X	X	X	X	—
HOUGHTON-BARAGA-KEWEENAW						
Samuel T. Sandell, MD, Houghton	X	X	X	X	X	X
HURON						
Charles W. Oakes, Jr., MD, Harbor Beach	X	X	X	X	X	X
INGHAM						
Herbert W. Harris, MD, Lansing	X	X	X	X	X	X
Lawrence A. Drolett, MD, East Lansing	X	X	X	X	X	X
Robert M. Stow, MD, Lansing	X	X	X	X	X	X
Justin L. Sleight, MD, Lansing	X	X	X	X	X	X

	Meetings					
	1st	2nd	3rd	4th	5th	6th
D. Bonta Hiscoe, MD, Lansing; and	X	—	X	X	X	X
John G. Wiegenstein, MD, Lansing	—	X	—	—	—	—
IONIA-MONTCALM						
Robert E. Rice, MD, Greenville	X	X	X	X	X	—
JACKSON						
Harold L. Oster, MD, Jackson	X	X	X	X	X	X
Francis P. McQuillan, MD, Jackson	X	X	X	—	X	X
KALAMAZOO						
Thomas E. Andrews, MD, Kalamazoo	X	X	X	X	X	X
Robert B. Burrell, MD, Kalamazoo	X	X	—	—	—	—
W. Kaye Locklin, MD, Kalamazoo	X	X	—	—	—	X
Douglass A. Haddock, MD, Kalamazoo	X	X	X	X	X	X
KENT						
Harvey M. Andre, MD, Grand Rapids	X	X	X	X	X	X
Richard A. Rasmussen, MD, Grand Rapids	X	X	X	X	—	X
Jack Hoogerhyde, MD, Grand Rapids	X	X	X	X	—	X
Victor A. Notier, MD, Grand Rapids	X	X	X	X	X	X
Kornelius Van Goor, MD, Grand Rapids	X	X	X	X	X	X
Noyes L. Avery, Jr., MD, Grand Rapids	X	X	X	X	X	X
Fred C. Brace, Grand Rapids	—	—	—	—	—	—
Frederick S. Gillett, MD, Grand Rapids	X	X	X	X	X	X
William Haeck, MD, Grand Rapids	X	X	X	X	X	X
LAPEER						
James R. Doty, MD, Lapeer	X	X	X	X	—	—
LENAWEE						
Donato F. Sarapo, MD, Adrian	X	X	X	X	X	X
LIVINGSTON						
Edwin S. Woodworth, MD, Howell	—	X	X	X	X	—
LUCE						
Bernard G. Keizer, MD, Newberry	—	—	—	—	—	—
MACOMB						
Charles M. Ebner, MD, St. Clair Shores	X	X	X	X	X	—
Peter V. Kane, MD, Mt. Clemens	X	X	X	X	—	—
Daniel L. Rousseau, MD, Mt. Clemens	X	X	—	—	—	—
Sydney Scher, MD, Mt. Clemens	X	X	X	—	X	—
MANISTEE						
Marlowe L. Schwartz, MD, Onekama	—	—	—	—	—	—
MARQUETTE-ALGER						
George M. Wilson, MD, Marquette	X	X	X	X	X	X
MASON						
William F. Sutter, MD, Ludington	X	X	X	X	X	—
MECOSTA-OSCEOLA-LAKE						
James L. Tyson, MD, Big Rapids	—	X	X	X	X	X
MENOMINEE						
Herman R. Burkardt, MD, Menominee	X	X	X	X	X	X
MIDLAND						
V. A. Marks, MD, Midland	X	X	X	X	X	X
MONROE						
S. Newton Kelso, Jr., MD, Monroe	X	X	X	X	—	—
MUSKEGON						
Howard V. Sanden, MD, Muskegon	X	X	X	X	X	X
H. Clay Tellman, MD, Muskegon	X	X	X	X	X	X
Robert J. Fles, MD, Muskegon	X	X	X	X	X	X
NEWAYGO						
J. Paul Klein, MD, Fremont	X	—	X	X	X	X
NORTH CENTRAL						
Charles L. Oppy, MD, Roscommon	X	X	X	X	X	—
NORTHERN MICHIGAN						
Richard A. Knecht, MD, Petoskey	—	—	—	X	X	X
OAKLAND						
Richard R. Galpin, MD, Birmingham	—	—	X	X	X	—
F. Michael Sheridan, MD, Royal Oak	X	X	X	X	—	X
Paul T. Lahti, MD, Royal Oak	X	X	X	X	X	X
Harold A. Furlong, MD, Pontiac	X	X	X	X	—	X
James R. Quinn, MD, Pontiac	X	X	X	X	X	X
John H. McLaughlin, MD, Birmingham	X	X	X	X	X	X
Shelby M. Baylis, MD, Pontiac	X	X	X	X	X	X

	Meetings					
	1st	2nd	3rd	4th	5th	6th
Edward E. Elder, Jr., MD, Pontiac	X	X	X	X	X	X
Arnold L. Brown, MD, Pontiac	X	X	X	X	X	X
James A. Read, MD, Birmingham	X	X	X	X	X	X
Bruce D. Bauer, MD, Hazel Park	X	X	X	X	X	X
Carl H. Birkelo, MD, Drayton Plains	X	X	—	X	—	X
OCEANA						
John J. Vrbanac, MD, Hart	X	X	X	X	X	X
ONTONAGON						
James P. Strong, MD, Ontonagon	—	—	—	—	—	—
OTTAWA						
William Rottschaefer, MD, Holland	X	X	X	X	X	X
SAGINAW						
Vernon V. Bass, MD, Saginaw	X	X	X	X	X	—
Robert J. Toteff, MD, Saginaw	X	X	X	X	X	X
Duane B. Heilbronn, MD, Saginaw; and	X	X	X	X	X	—
Edward F. Kickham, MD, Saginaw	—	—	—	—	—	X
ST. CLAIR						
Anthony C. Gholz, MD, Port Huron	X	X	X	X	X	X
James H. Tisdel, MD, Port Huron	X	X	X	X	X	X
ST. JOSEPH						
Stanley C. Penzotti, MD, Three Rivers	X	X	X	X	X	X
SANILAC						
Keate T. McGunegle, MD, Sandusky	X	X	X	X	X	X
SHIAWASSEE						
Claude L. Weston, MD, Owosso	X	X	X	X	X	X
TUSCOLA						
Robert R. Howlett, MD, Caro	—	—	—	—	—	—
VAN BUREN						
Edwin H. Terwilliger, MD, South Haven	X	X	X	X	X	X
WASHTENAW						
Clarence E. Crook, MD, Ann Arbor	X	X	X	X	X	X
L. Dell Henry, MD, Ann Arbor	X	X	X	X	X	X
Henry A. Scovill, MD, Ypsilanti	X	X	X	X	X	X
Harry A. Towsley, MD, Ann Arbor	X	X	X	X	—	X
Stuart M. Gould, Jr., MD, Ann Arbor; and	X	X	—	—	—	—
George H. Koepke, MD, Ann Arbor; and	—	—	X	—	—	—
William R. Rekshan, MD, Ann Arbor	—	—	—	X	X	X
John W. Henderson, MD, Ann Arbor	X	X	X	X	X	X
Beverly C. Payne, MD, Ann Arbor	X	X	X	X	X	X
Howard R. Williams, MD, Ann Arbor	X	X	X	X	X	X
Robert J. Fisher, MD, Ypsilanti	—	—	—	—	—	—
WAYNE						
Frank B. Bicknell, MD, Detroit	X	X	X	X	X	X
James C. Danforth, Jr., MD, Grosse Pte. Wds.	X	X	X	X	X	X
Wyman C. C. Cole, Jr., MD, Detroit	X	X	X	X	X	X
James B. Blodgett, MD, Detroit	X	X	X	X	X	—
Donald N. Sweeny, Jr., MD, Detroit	X	X	X	X	—	X
Brock E. Brush, MD, Detroit	X	X	X	—	—	—
Sidney Adler, MD, Detroit	X	X	X	X	—	—
James D. Fryfogle, MD, Southfield	X	X	X	X	X	X
James J. Lightbody, MD, Detroit	X	X	X	X	X	X
Homer M. Smathers, MD, Detroit	X	X	X	X	X	X
Edward J. Tallant, MD, Detroit	X	X	X	X	—	X
Charles E. Darling, MD, Detroit	X	X	X	X	X	X
George L. Reno, MD, Detroit	X	X	X	X	X	X
Paul J. Connolly, MD, Detroit	X	X	X	X	—	X
Louis E. Heideman, MD, Detroit	X	X	X	—	—	—
Marjorie P. Meyers, MD, Detroit	X	X	X	X	—	X
George T. Bradley, MD, Detroit	X	X	X	—	—	—
Francis P. Rhoades, MD, Detroit	X	X	X	X	X	X
Russell F. Fenton, MD, Detroit	X	—	—	—	—	—
John G. Slevin, MD, Grosse Pte. Pk.	X	X	X	X	X	X
Louis Carbone, MD, Detroit	X	X	X	X	X	X
C. Jackson France, MD, Detroit	X	X	X	X	X	X
Raymond A. Sokolov, MD, Detroit	X	—	—	—	—	—
Alexander Blain, III, MD, Detroit	X	X	X	X	X	X
Norman D. Nigro, MD, Detroit	X	X	X	X	—	—
John W. Moses, MD, Detroit	—	X	X	X	X	X
Alfred H. Whittaker, MD, Grosse Pte.	X	X	X	X	X	X
Sidney E. Chapin, MD, Dearborn	X	X	X	X	X	X
William L. Brosius, MD, Rochester	X	X	X	X	X	X
Robert H. Hamburg, MD, Detroit	X	X	X	X	X	X
James M. Kennary, MD, Detroit	X	X	X	X	X	—
William J. Yott, MD, Detroit	X	X	X	—	—	X
Irvin A. Wilner, MD, Detroit	X	X	X	X	—	—
Homer A. Howes, MD, Detroit	X	X	X	X	X	X
Joseph A. Witter, MD, Highland Park	X	X	X	X	—	X
Benjamin Jeffries, MD, Harper Woods	—	X	X	X	X	X
Mario A. Petrini, MD, Detroit	—	—	—	—	—	—
H. Ross Hume, MD, Detroit	X	X	X	X	X	—
Arthur B. Levant, MD, Detroit	X	X	X	X	X	X
Henry M. Donzalski, MD, Detroit	X	X	X	X	X	X
Eli J. Igna, MD, Detroit	X	X	X	X	X	X
Fred W. Whitehouse, MD, Detroit	X	X	X	X	X	X
Paul R. Dumke, MD, Detroit	X	X	X	X	X	X
John W. Sigler, MD, Detroit	X	X	X	X	X	X
Laurel S. Eno, MD, Detroit	X	X	X	X	X	X
Robert D. Allaben, MD, Detroit	X	X	X	X	X	X
Vincent J. Gallant, MD, Detroit	X	X	X	X	X	X
Fred E. Caumartin, MD, Detroit	X	X	—	—	X	X

	Meetings					
	1st	2nd	3rd	4th	5th	6t
Walter F. Kukawski, MD, Detroit	X	X	X	—	—	—
Lee E. Feldkamp, MD, Plymouth	X	—	X	X	X	X
E. Clarkson Long, MD, Detroit	X	X	X	X	X	X
Frank B. Walker, MD, Grosse Pte.	X	X	X	X	X	X
Everal M. Wakeman, MD, Dearborn	X	X	X	X	X	X
Clayton M. Shors, MD, Grosse Pte. Woods	X	X	X	X	X	X
Jean M. Holdredge, MD, Detroit	X	X	X	X	X	X
Robert B. Clarke, MD, Detroit	X	X	X	X	X	X
WEXFORD-MISSAUKEE						
Dennis E. Van Alst, MD, Cadillac	X	X	X	X	X	X
ALLERGY AND APPLIED IMMUNOLOGY						
James A. McLean, MD, Ann Arbor	X	X	X	X	X	X
ANESTHESIOLOGY						
Ralph F. Askam, MD, Muskegon	—	X	X	X	X	X
DERMATOLOGY						
Robert J. Schoenfeld, MD, Birmingham	—	—	—	—	—	—
GASTROENTEROLOGY						
Irving A. Warren, MD, Detroit	—	—	—	—	—	—
GENERAL PRACTICE						
Clare C. Huggett, MD, Lansing	X	X	X	X	X	X
GYNECOLOGY AND OBSTETRICS						
Howard R. Williams, MD, Ann Arbor	—	—	—	—	—	—
INTERNAL MEDICINE						
Carl B. Beeman, MD, Grand Rapids	—	—	—	—	—	—
MICHIGAN ASSOCIATION OF NEUROLOGICAL SURGEONS (Section on Neurological Surgery)						
H. Harvey Gass, Detroit	—	—	—	—	—	—
OCCUPATIONAL MEDICINE						
Benjamin B. Holder, MD, Midland	—	—	—	—	—	—
OPHTHALMOLOGY						
James L. Frey, MD, Detroit	—	—	—	—	—	—
OTOLARYNGOLOGY						
G. Donald Albers, MD, Grand Rapids	—	—	—	—	—	—
ORTHOPEDIC SURGERY						
Hira E. Branch, MD, Flint	X	X	X	X	—	—
PATHOLOGY						
John R. McDonald, MD, Detroit	—	—	—	—	—	—
PEDIATRICS						
(Not represented)						
PLASTIC SURGERY						
Edward J. Hill, Jr., MD, Detroit	—	—	—	—	—	—
PROCTOLOGY						
Donald J. Pearson, MD, Battle Creek	—	—	X	X	X	X
PSYCHIATRY AND NEUROLOGY						
Robert B. Clarke, MD, Detroit	X	—	X	X	X	X
PUBLIC HEALTH AND PREVENTIVE MEDICINE						
G. Frederick Moench, MD, Sanford	—	—	—	—	—	—
RADIOLOGY						
Benjamin R. Van Zwalenburg, MD, Grand Rapids	X	X	X	X	X	X
SURGERY						
John W. Derr, MD, Detroit	—	—	—	—	—	—
UROLOGY						
Murray S. Mahlin, MD, Detroit	—	—	—	—	—	—
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UNIVERSITY OF MICHIGAN						
Judith Ascher	—	X	—	—	—	—
Doug Faber	X	X	X	X	—	—
Walter Faggett	X	X	X	X	X	—
Jay K. Harness	X	X	—	—	—	—
R. A. Lewis	—	X	X	X	X	—
Richard Livesay	X	X	X	—	—	—
WAYNE STATE UNIVERSITY						
Lawrence Brilliant	X	X	X	X	X	—
Ronald Holmes	X	X	X	—	—	—
Robert Levine	X	X	X	X	—	—
Gene Schwartz	X	X	X	X	—	—
John Sealy	X	X	X	—	—	—
Richard Tirrell	X	—	X	X	X	—

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MICHIGAN

VOLUME 66, JULY 1967, NUMBER 14 — NEWS EXTRA — DEADLINE JULY 20

AMA and MSMS Issue Appeal: "Write your Congressmen on Chiropractic Issue"

Every MSMS member is urged to act on the AMA's appeal to all physicians to contact their congressmen at once in view of pending legislation. There is a serious threat that chiropractic will become eligible for payment under HR 5710 (Medicare).

Endorsing the AMA's request, MSMS President C. Allen Payne, M.D., Grand Rapids, urges all Michigan physicians to write their congressmen and to send copies of the letter to Representative Wilbur D. Mills, Chairman of the House Ways and Means Committee, which is currently reviewing the bill.

"It is most important," Doctor Payne adds, "that copies of the letters go to Chairman Mills."

"The inclusion in House Resolution 5710 (Medicare) of payment for chiropractic services would constitute a serious hazard to health care of the elderly, and it would create for them an intolerable double standard of care," the MSMS President stresses.

F. J. L. Blasingame, M.D., AMA Executive Vice President, says in the telegram to MSMS members, "Chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease." Furthermore, Doctor Blasingame continues, "Chiropractic constitutes a hazard to rational health care because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational and unscientific approach to the causes of disease."

When writing to congressmen, Doctor Payne urges that physicians include the following ten specific points:

1. No chiropractic school is accredited by any recognized educational accrediting agency in the United States.

2. The Doctor of Chiropractic degree, D.C., is listed as spurious by the United States Office of Education in the recent publication *Academic Degrees*. (A spurious degree is one purporting to be a legitimate degree duplicating those given by legitimate institutions, but in fact granted by diploma mills, or it is a degree not granted or offered by a legitimate institution, but unique to the granting institution.)

3. Chiropractic students and chiropractic schools are not included in new programs such as health professions education improvement grants, health professions student scholarships, and health professions student loans.

4. Chiropractors are not granted health commissions as officers in the United States Armed Forces.

5. Chiropractors are not eligible for appointments as staff officers or allowed to practice at United States Veteran Administration hospitals.

6. Chiropractic groups publicly have opposed school immunization programs and community fluoridation programs, both of which are endorsed by the United States Public Health Service.

7. Chiropractors are not allowed to practice in any hospitals accredited by the Joint Commission on Accreditation of Hospitals.

8. Chiropractors are licensed by the various states only on a limited basis and are not allowed, in any state, to prescribe drugs or to perform surgery. Owing to the wide variance in the chiropractic state licensing laws, the matter of standardizing chiropractic claims throughout the United States would provide a difficult and intolerable burden on the Social Security Administration.

9. A three-judge federal district court in the case of *England* vs *Louisiana Board of Medical Examiners* has ruled that since chiropractic holds itself up as a complete health-care service, a state may refuse to license chiropractors if they fail to meet the same educational standards required of medical doctors. This ruling was upheld by the United States Supreme Court.

10. The Principles of Medical Ethics state that it is unethical for a doctor of medicine to associate professionally with a cultist (chiropractor).

"It is vital," Doctor Payne repeats, "that physicians act now to prevent the inclusion of chiropractic in the Medicare law."

Eight MSMS-Sponsored Medical Bills Now Law; No Detrimental Bills Passed

BY M. A. RILEY
MSMS LEGISLATIVE REPRESENTATIVE

Eight new health laws have been placed on the Michigan statute books at the urging of the Michigan State Medical Society during 1967.

MSMS has sponsored or endorsed 14 health-related bills introduced this year in the State Legislature and well over half of them were approved by the lawmakers and sent to the Governor for signature.

In addition, an MSMS-supported resolution was adopted by both the State Senate and House of Representatives, calling for an in-depth study of the proper scope of practice of the various "healing arts" and paramedical fields.

No bill judged by MSMS to be detrimental to the best health interests of the people of Michigan was cleared through the legislative process. Chief among the proposals rejected were bills to expand the practices of chiropractors and optometrists, and several other bills which were carefully examined by the MSMS Legal Affairs Committee and found to be ill-conceived.

NEW STATUTES successfully sought by MSMS include a bill permitting the State Board of Medical Examiners to accept, in lieu of examination, certificates of the National Board of Medical Examiners; a new law which will exempt from liability the members of hospital in-staff committees performing their duties for the purpose of reducing morbidity or mortality; a re-written Michigan Nurse Practice Act clearly permitting physicians to assign tasks to unlicensed persons; a law which declares that the transfusion of blood is the performance of a service and is not a "sale"; an amendment to the reporting requirements under the PKU law as requested by the 1966 MSMS House of Delegates; a new hospital licensing (not franchising) law for the State of Michigan which sets standards for all hospitals but specifically provides that there shall be no regulation of the medical or surgical treatment provided a patient by licensed medical personnel; an "implied consent" law for Michigan which protects the individual drawing blood but purposely emphasizes a breath test for determination of intoxication; a a new law, endorsed by MSM which will ban certain extreme dangerous types of fire extinguis ers from sale or use in priva homes or automobiles.

Other measures sponsored endorsed by MSMS, which fail to pass in the present session b are still eligible for considerati in January of 1968, include t repeal of the now-outdated Bas Science Law; legislation to licen and regulate medical laboratorie legislation to spell out qualific tions for the State Director Mental Health; legislation to s forth qualifications for the Sta Director of Mental Health; legi lation to create a policy-maki Board of Public Health; legisl tion to create a policy-maki Mental Health Commission, an legislation to extend the medic examiner system to addition areas of the state.

DURING THE present sessio MSMS vigorously and successful opposed several proposals whic would have compelled medical e aminers to conduct coronors' i quests, a proposal which woul have required physicians to repo suspected mental retardation i newborns, and many others.

In addition to the 14 bills d rectly urged by MSMS, the Leg Affairs Committee found it nece sary to carefully study 107 bills i troduced from all sources (stat agencies, health groups, etc.). C the 24 health bills finally enacte into law, fully one-third bore th MSMS label and the remaining 1 were all approved by the commi tee. Twenty-two bills were deeme undesirable by MSMS, and non of these was passed.

Bills introduced in the presen session, however, are still eligibl for passage next year.

Commencing with the Augus issue of *Michigan Medicine* an regularly in succeeding journal articles will appear explaining i detail the content and meaning o the health laws passed by th 1967 Legislature.

No Easy Task! Careers Mobile Now on Island

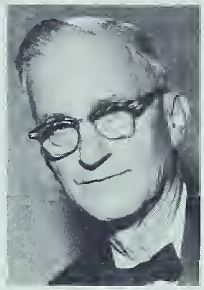
Getting the Health Careers Mobile onto Mackinac Island, where it is now, took considerable engineering skill, lots of patience, and maybe even a bit of luck.

It was quite a feat to maneuver the 12 x 50 foot unit onto the Mackinac College Barge to reach the Island, then transport it by tractor to its downtown position adjacent to the Health Center, on Market Street. There the Mobile is drawing several hundred viewers per day.

Manned by student nurses, volunteer women, and Islanders, the Health Careers Mobile is operated under the auspices of the Michigan Health Council and the Michigan State Medical Society and directed by Joseph A. Solomon, M.D., Mackinac Island, President of the Chippewa-Mackinac Medical Society, Stella King, R.N., and Miss Jackie Anderson, of his staff.

The Careers Mobile will move next to the Macomb Mall, July 24-29.

Members in the Spotlight



William S. Jones, M.D., Menominee, recently installed as President of the Upper Peninsula Medical Society. He was President of MSMS in 1955-56. See Page 942 for details.

George W. Slagle, M.D., Battle Creek, recently reelected to the AMA Council on Medical Service. Another MSMS Past President, he led the Society in 1957-58. See August *Michigan Medicine*.

James J. Lightbody, M.D., Detroit, who will preside at the 1967 MSMS House of Delegates, September 24-25-26, in Grand Rapids. See August issue of *Michigan Medicine* for details.

Harry A. Towsley, M.D., Ann Arbor, who is Chairman for the 1967 MSMS Annual Session Scientific Session Program Commitee. See blue pages in July issue of *Michigan Medicine* for speakers, subjects, etc.

G. B. Saltonstall, M.D., Charlevoix, recently elected President of the Michigan Association of the Professions. He led MSMS as President in 1958-59. See Page **941** for details.

T OUT AND RETURN THIS BLANK R VALUABLE MATERIALS . . .

The following materials may be useful to you. Check any item de- , cut out the form, and mail it in an envelope to: Michigan State ical Society. 120 West Saginaw, East Lansing, Michigan 48823. r address already is on the back of this coupon.

____AMA-prepared speech on Health Career Opportunities for use with students, clubs, etc.

____Doctor's Emergency Handbook on Medicare, published by Prentice-Hall.

____Folder describing "AMA Policy Statement on Fluoridation of Public Water Supplies."

____AMA catalog of "Motion Pictures on Health."

____"The American Economic Scene at Mid-Century," by Clyde T. Hardwick, Ph.D., MSMS Economics Consultant.

____Medi-labels, medical identification labels to attach to drivers' licenses.

ADD: IN MEMORIAM

News of the following deaths of members has reached the MSMS office. Details will follow in the August issue of *Michigan Medicine.*

Wesley M. Burling, M.D., Grand Rapids, died June 26.

Charles B. Fleischmann, M.D., Muskegon, died May 15.

Evan L. Garrett, M.D., Niles, died May 27.

Norman L. Lindquist, M.D., Escanaba, died June 19.

John J. Miller, M.D., Marne, died June 19.

Max Rulney, M.D., Flint, died March 13.

Lawrence N. Upjohn, M.D., Kalamazoo, died June 2.

Saltonstall Now MAP President

G. B. Saltonstall, M.D., Charlevoix, is the new President of the Michigan Association of the Professions.

Doctor Saltonstall was President of the Michigan State Medical Society in 1958-59 and served as a MSMS representative to the meeting in December, 1958, when MAP was incorporated. He has been a member of the MAP board continuously and had served this past year as Vice-President.

Among the members of the Executive Committee is J. Russell Brink, M.D., of Grand Rapids. Among those serving on the Board of Directors is MSMS Past President Luther R. Leader, M.D., Royal Oak.

HEAR MSMS OFFICIALS

C. Allen Payne, M.D., MSMS President, and Robert J. Mason, M.D., Council Chairman, spoke at a University of Michigan intern and resident orientation program July 1 and 2.

resident orientation program July 1 and 2.

Doctors Payne and Mason described Michigan's concepts of professional practice to 151 interns and residents.

Did You Save Blue Section?

Michigan Medicine Carries Annual Session Program

Did you save the 1967 Annual Session Program that appeared in the July issue of *Michigan Medicine*?

MSMS members are urged to study the subjects and speakers and decide to attend.

The dates again, September 27-28-29; after the House of Delegates, September 24-25-26.

For the first time, all scientific meetings and exhibits will be on one floor of the Civic Auditorium.

Three or four concurrent scientific meetings will be held in assemblies adjacent to the exhibit area.

Luncheons each day will feature informal discussion during the meal with guest lecturers seated at various tables throughout the room.

MSMS Sections will present scientific programs of interest to doctor registrants and all scientific meetings will be open to all. Some of the sections plan receptions and dinner meetings in addition to the scientific program presentation.

The Annual Dinner Dance will be held on Wednesday evening, September 27. An evening session on Thursday, September 28, will be open to the public — discussing Family Life Education.

The scientific program committee has planned a program of broad scope with practical applications in the physician's home practice.

Coller-Penberthy-Thirlby Program Set, June 27-28

Traverse City—According to the Program Committee for the 47th Annual Coller-Penberthy-Thirlby Medical Conference this year's session will be better than ever. After reviewing the abstracts submitted by the speakers, the Committee reports that much new knowledge will be presented at the meeting.

Participating on the program are seven out-of-state authorities and many Michigan experts.

All Michigan physicians are invited to attend the Conference in Traverse City at the Park Place Motor Inn, July 27-28.

Wade in Vietnam On AMA Program

Franklin V. Wade, M.D., Flint surgeon, is the most recent Michigan physician giving of his services in Vietnam.

Doctor Wade left on July 14 to work with the civilian population in South Vietnam under the Volunteer Physicians for Vietnam program of the AMA.

Jones to Lead U.P. Society In 75th Year

William S. Jones, M.D., Menominee, a MSMS Past President, will be the president this year of the Upper Peninsula Medical Society, during its Diamond Anniversary, and Percy Murphy, M.D., Ironwood, has been selected as president-elect.

The 1968 session will be held in Ironwood.

A need for more medical manpower and more effective postgraduate medical education were stressed by MSMS President C. Allen Payne, M.D., in his address at the 74th Annual Meeting, in Escanaba. "The Michigan State Medical Society," Doctor Payne said, "is trying to influence the Legislature and is cooperating with medical education to train more doctors and paramedical personnel."

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Michigan Medicine

MICHIGAN MEDICINE
VOLUME 66, AUGUST 1967, NUMBER 16 — NEWS EXTRA — DEADLINE AUGUST 14

Another victim is tagged.

President-Elect Of AMA to Speak To MSMS Delegates

Dwight L. Wilbur, M.D., President-Elect of the American Medical Association, will speak to the MSMS House of Delegates on Sunday, September 24, at 8:30 PM in Grand Rapids at the Pantlind Hotel. The invitation to speak was extended by James J. Lightbody, M.D., Detroit, Speaker of the MSMS House of Delegates. All sessions of the House of Delegates, as stressed in the August issue of *Michigan Medicine,* are open to all interested MSMS members.

The election of Doctor Wilbur by the 1967 AMA House of Delegates marked the first time in the 120-year history that a son of a former president was named to be elevated to the presidency. The late Ray Lyman Wilbur, M.D., was the 76th AMA president in 1923-24.

Doctor Wilbur is a past president of the American College of Physicians and the American Gastroenterological Association.

The Annual Scientific Session will be September 27-28-29 at the Civic Auditorium with an outstanding array of speakers on vital subjects.

728 Riot Victims Treated; Disaster Plan Worked Well

BY PETER HOHEISEL
OF THE MSMS STAFF

With the sounds of small scale war echoing in the streets of Detroit, physicians, nurses, and ancillary personnel worked around the clock in the hospitals of the city to bring effective medical care to the hundreds of riot victims.

For three days they poured in. The fireman shot between the eyes. The small child with minor lacerations. The sniper with only a small patch of blood on his T-shirt indicating a bullet hole in his stomach.

All patients received the best and most efficient care which American medicine can offer today.

AND WHILE DETROIT hospitals felt the effects of the riot, Henry Ford, Highland Park, and Detroit General Hospital were the most involved, with Detroit General bearing the brunt.

Brock E. Brush, M.D., staff surgeon at Henry Ford Hospital, was one of the hundreds of physicians who worked day and night in the crisis. He summarized the work of the physicians who gave so much of themselves this way: "The response of the medical community to the emergency was superb and efficient. Doctors cancelled vacations and medical society business and worked around the clock.

"Also," he added, "The Wayne County Medical Society Disaster Committee with its training programs has proved beneficial since several emergency rooms in hospitals quickly organized to handle a much greater load than was ordinarily taken care of."

FOR THE FIRST TIME since its conception, a carefully articulated Disaster Plan went into effect at 7:30 PM, Sun-

(Continued on Page 1054)

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Med Students Push Plans for Jeffries Center

Looking over plans at the Jeffries Community Health Center are, from left to right: John Fisher, personnel coordinator and medical student; Sue Ekstrom, social work student; Frank Morgan, member of communications committee; Thomas A. Bruce, M.D., assistant dean of the Wayne School of Medicine, an unofficial advisor to the group; and Harold Jayne, summer coordinator and medical student.

Carpenters, plumbers, and electricians are giving final shape t the Jeffries Community Healt Center, an experiment in healt care for the inner city poor, initiated by WSU medical students.

The Center, located at 1301 Selden, is on the ground level of on of the apartment buildings in th Jeffries Housing Project in Detroit. The project is sponsored b the Student Health Organization and will involve students and local people on committees.

Space and renovation costs hav been donated to the clinic by th Detroit Housing Commission.

More than 40 physicians hav volunteered their services.

"The people here don't want hand-out clinic," observes Harol Jayne, coordinator of the clinic "They have already decided tha a fee should be charged.

"Also we're trying to rais money on a local level," he continued. "We've had a fund raisin barbecue and are planning mor activities like this."

The project promises to be an excellent educational experienc for the students because of involvement in the community, working with professionals, and working with social work, pharmacy, and nursing students. We expect to learn from each other, declares Thomas A. Bruce, M.D., Assistant Dean of Medicine at WSU, one of the early supporters of the project.

"Right now what we need most is money. We would appreciate any financial help. Checks should be made payable to: West Side Health Clinic, Michigan Non-Profit Charitable Corporation, the corporate title of Jeffries Community Health Center," concluded Mr. Jayne.

Continued: Detroit Disaster

day night, July 23, at Detroit General. Practice runs had removed some of the bugs in the system such as where the emergency facilities could best be expanded to handle a large influx of patients. But the test came in the three days of fire and violence.

Elements in the plan, according to Alexander Walt, M.D., chief of surgery at Detroit General and chairman of the surgery department at Wayne State University's School of Medicine, were personnel, supplies, and space for patients.

"As far as personnel goes," Doctor Walt continued, "we actually had more help than we needed. Full-time staff physicians lived in the hospital. We called in all residents and also some medical students. Our ambulances carried nurses back and forth to the hospital on shifts."

CORE OF THE PLAN was the *triage* system, originally used in war hospitals, and based on the principle of quick diagnosis and treatment according to severity of injury.

Ambulances, fire trucks, and police wagons poured into the courtyard at the emergency dock of the hospital. Teams of physicians immediately diagnosed the casualties as soon as they were unloaded. Then the patients were tagged and assigned to emergency rooms according to degree of severity and need for immediate treatment. Rotating teams of physicians, nurses, and medical students waited to administer immediate care in the emergency rooms. At the peak of the crisis, 100 physicians were at work. When it was all over 728 riot victims had been cared for.

"We're extremely pleased with the way the plan worked," said Edward P. Henry, administrator at Detroit General.

"We're also grateful to the Wayne County Medical Society which, at the height of the crisis, gave us official word that they were standing by to help in any way possible," Mr. Henry added.

"IF SUCH A SITUATION arises again," he concluded, "the only thing we would change is to have more rotation of physicians and better housing for ancillary personnel who are staying at the hospital."

leustis Leaves tate Post to irect MARMP

Albert E. Heustis, M.D., who ıs served for 19 years as State Di- ctor of Public Health, will re- gn his post September 30 to be- me Director of the Michigan As- ciation of Regional Medical Pro- ams.

“To coordinate the war against ncer, heart disease, and stroke ,” according to Doctor Heustis, a real opportunity and a timely ne.”

MARMP, formed as a non-profit rganization, received a grant re- ently of $1,285,155 from the U.S. ublic Health Service National In- itutes of Health. Designed to age a Michigan war against the hree deadliest diseases, MARMP ncludes MSMS, the three medical chools, the Michigan Department f Public Health, and other health rganizations.

The new Association will have ts office in Lansing with a staff of our to six persons.

Accepting the resignation of Dr. Heustis “with great regret,” Gov- rnor Romney praised him as “an utstanding public servant. He has arned distinction not only for himself but for the State of Mich- gan.”

WSU Students Hear Rouse

Milford O. Rouse, M.D., President of the AMA, addressed third and fourth year medical school students of WSU there August 18. AMA Delegate Donald N. Sweeny, Jr., Detroit, helped to make the arrangements.

State to Mark "Health Week"

“County Medical Societies have a wealth of material available to them for this year’s Community Health Week, October 15-21,” according to Brock E. Brush, M.D., Chairman of the MSMS Public Relations Committee.

“The 1967 Community Health Week,” Doctor Brush explained, “will concentrate on three themes: health education regarding venereal disease; medical and paramedical career opportunities; and information on immunization, particularly measles. A kit is available on request from the AMA through MSMS.”

MSMS is again cooperating with the Michigan Health Council and Michigan Association of the Professions in the promotion of Community Health Week in Michigan. Many details were advanced at the meeting of the MSMS Public Relations Committee August 9.

New Law Quoted on Measles Immunization For Kindergartners

Some questions have been received at MSMS about the new state requirement that incoming kindergarten children must obtain immunization against measles before entering school this fall.

The following explanation is offered.

Section 376 of Public Acts of 1955 has been amended by the addition of measles to those diseases for which protection is required at the time of entering school. The tuberculin test requirement was added in 1965 and became effective that year.

The latest revision was signed into law by Governor Romney, July 11, 1966 and became effective January 1, 1967. The section now reads as follows:

> “Sec. 376. All children enrolling in any public, parochial or denominational school in Michigan for the first time shall submit either a statement signed by a physician that they have been immunized or protected against smallpox, diphtheria, tetanus, pertussis, measles and poliomyelitis, and tuberculin tested to determine the presence of infection from tuberculosis; a statement signed by a parent or guardian to the effect that the child has not been immunized and tuberculin tested because of religious convictions or other objection to immunization; or a request signed by a parent or guardian that the local health department give the needed protective injections and diagnostic test.
>
> “Prior to November 1 of each year, the administrator of each school shall provide the state director of public health with the immunization and tuberculin status of each entering child. This information shall be transmitted through the approved local full-time health department wherever the same exists and shall be on forms provided by the state director of public health or otherwise reported in a manner approved by it.”

Attention of parents is being called by MSMS to the importance that children obtain preschool physical examinations as soon as possible to avoid the September rush.

T OUT AND RETURN THIS FORM ORDER VALUABLE MATERIALS

The following material may be useful to you. Check any item red, cut out the form, and mail it in an envelope to: Michigan e Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.

______**Maternal Health Desk Reference Card Number 9, “The Management of the RH-Sensitized Patient.”**

______**Drugs Anonymous? Booklet published by the Pharmaceutical Manufacturers Association.**

______**Membership Application for MDPAC-AMPAC.**

______**Baby Emergencies Poster, produced by Michigan Health Council.**

______**Smoking and Its Relationship to Health and Disease, Michigan Council on Smoking and Health Guidebook.**

(Your address already is on the back of this cut-out coupon)

Time to Reserve Hotel Room for Annual Session

With the Annual Session just a month away, all physicians are urged to make reservations now so as to partake fully of the excellent scientific program which is planned.

"Write or phone the Pantlind Hotel in Grand Rapids and then mark your calendar for Wednesday morning, September 27 through Friday noon the 29th," MSMS officers urge.

The center section of July *Michigan Medicine* carried the program for the scientific meeting. Details about ancillary groups will appear in the September issue.

Wilcox to Succeed Cummings at Lab

The new chief of the Bureau of Laboratories and the associate director of the Michigan Department of Public Health is Kenneth Wilcox, M.D., Lansing.

Doctor Wilcox was appointed to fill the vacancy created by the death of G. D. Cummings, M.D., Lansing, who died July 27.

Doctor Wilcox has been with the Department since 1962.

Details about the many contributions by Doctor Cummings will appear in the September issue of *Michigan Medicine.*

Thousands of tourists this summer will see the MSMS memorial to William Beaumont, M.D., at Mackinac Island from the unique carriages or as they hike or bike on the island, a popular summer tourist attraction. As in the past, a girl guide lectures to the visitors in the building telling them about the work of the famed Michigan physician.

MSMS COUNCILORS PLAN CONFERENCES

MSMS Councilor Conferences are being set up for the time between August 15 and the Annual Session.

Invitations are being sent to county society officers, delegates, alternate delegates, and section delegates. Individual meeting notices will be sent out by each Councilor.

TWO NATIONAL CONCLAVES AT U-M IN SEPTEMBER

The annual meeting of the American Thyroid Association will be held September 14-16.

The American Academy of Child Psychiatry will hold its annual meeting September 29-October 1.

CAREERS MOBILE LOG:

Midland, County Fair, Augus 14-21

Detroit, State Fair, August 25 September 5

St. Louis, Fall Festival, September 6-9

Flint, Central High School Location, September 11-18

Grand Rapids, Annual Session September 20-29

ADD: IN MEMORIAM

News of the following recent deaths has reached the MSMS Headquarters. The details will follow in the September issue of *Michigan Medicine.*

Frank A. Adams, M.D., Grand Rapids, August 6.

G. Donald Cummings, M.D., Lansing, died July 27.

Ernest W. Dales, M.D., Grand Rapids, died July 25.

Gerald DeMaagd, M.D., Rockford, died July 13.

L. Warren Gatley, M.D., Pontiac, died July 17.

Harold Henderson, M.D., Southfield, August 8.

Kenneth B. Keeler, M.D., Albion, died July 15.

John S. Lambie, M.D., Birmingham, died June 25.

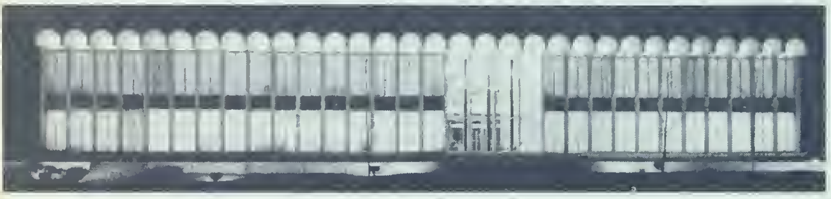
Robert J. McGillicuddy, M.D., Lansing, died July 27.

George L. Hagman, M.D., Medford, Oregon, died May 28.

Allan L. Richardson, M.D., Detroit, died July 27.

Robert D. Scott, M.D., Flint, died July 10.

Second Class Postage Paid at Lansing, Mich.



MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY

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MICHIGAN MEDICINE
VOLUME 66, SEPTEMBER 1967, NUMBER 18 — NEWS EXTRA — DEADLINE AUGUST 30

Here Is Advance Copy of Program:

Urge Every MSMS Member To Attend '67 Annual Session

It's that time of year again!

Yes, that very important time, the season for the MSMS Annual Scientific Session, September 27-29 in Grand Rapids.

In this 102nd year of the Society, MSMS officials and staff are working to surpass previous scientific sessions by presenting an even greater array of programs and exhibits. In addition to the fine opportunity for postgraduate education, physicians will have a chance to renew old friendships and make new ones through alumni groups and other social activities. Following tradition, the Scientific Session will follow the three-day meetings of the MSMS House of Delegates.

NEW AT THE Scientific Session this year will be: a one-floor plan whereby all meetings and exhibits are held on the main floor of the Civic Auditorium, thus eliminating trudging up and down stairs from exhibit hall to programs; a new plan for luncheons so that physicians may meet speakers for informal discussions; curbstone consultations; an open question-and-answer period where representatives of the Michigan agencies operating Medicare and Medicaid will discuss any problems or complaints physicians might have.

More than 25 outstate authorities and over 50 Michigan experts will speak on a wide variety of topics of interest to every physician. They will present their views at round table discussions, seminars, symposiums, clinics, curbstone consultations, and special meetings. At any hour three different programs will be available.

"THE INTIMACY OF round table discussions, seminars, and clinical conferences," says Harry A. Towsley, M.D., Chairman of the Program Committee, "will provide an unusual opportunity for every doctor present to meet personally and talk over mutual problems, not only with the scheduled discussants, but with his peers and colleagues as well. Physicians from medical centers throughout the state and nation, known for their scientific contributions through research, effective teaching ability, administrative judgment, and, in particular, their thoughtful consideration in the care of patients have been selected as participants for this outstanding program."

Two special programs will be featured at this year's session: a public forum on "Family Life and Sex Education" on Thursday evening and the Fifth Annual Conference on Nutrition and Diet Therapy on Wednesday and Thursday.

MANY MSMS SECTIONS will hold meetings as will many Michigan branches of national professional societies. The annual State Society Dinner Dance will be Wednesday evening, and there MSMS officers will be installed for the coming year. The MDPAC Breakfast on Wednesday morning will feature House Minority Leader Gerald Ford as keynote speaker. The Annual Doctors and Wives Art Show will be open for viewing Wednesday and Thursday.

In the rush to get schedules arranged to attend the Annual Session, physicians are urged to remember that the Woman's Auxiliary is holding its own convention Tuesday through Thursday at the Pantlind Hotel. An interesting program has been planned for all doctors' wives. Office assistants may ask for time off, too, to attend the Michigan State Medical Assistants Society convention at the Morton House, also Tuesday through Thursday.

"TAKE ADVANTAGE of the opportunities being offered to gain new and useful information, renew old acquaintances and make new ones, and relax, if only for a few days, from your busy practice at this year's session of MSMS!" urges Doctor Towsley. "You owe it to yourself, to your patients, and to your family."

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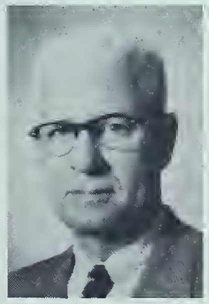
Preliminary Program

1967 Annual Scientific Session
Grand Rapids Civic Auditorium/Pantlind Hotel
September 27-28-29, 1967


H. H. Hiscock, M.D.
Annual Session
General Chairman

H. A. Towsley, M.D.
Chairman
Program Committee

D. L. Kessler, M.D.
Local Chairman
Of Arrangements

C. E. Booher, M.D.
Chairman, Scientific
Exhibits Committee

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REGISTRATION

MICHIGAN STATE MEDICAL SOCIETY Main Lobby, Civic Auditorium	Monday, September 25	8:00 a.m. – 10:00 p.m.
	Tuesday, September 26	8:00 a.m. – 10:00 p.m.
	Wednesday, September 27	8:00 a.m. – 5:30 p.m.
	Thursday, September 28	8:00 a.m. – 5:30 p.m.
	Friday, September 29	8:00 a.m. – 2:00 p.m.
WOMAN'S AUXILIARY Lobby, Pantlind Hotel	Tuesday, September 26	9:30 a.m. – 4:00 p.m.
	Wednesday, September 27	8:00 a.m. – 4:00 p.m.
	Thursday, September 28	8:00 a.m. – 12:00 noon
MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY Mezzanine, Morton House	Tuesday, September 26	6:00 a.m. – 10:00 p.m.
	Wednesday, September 27	7:00 a.m. – 12:00 noon
	Thursday, September 28	8:00 a.m. – 9:00 a.m.
CONFERENCE ON NUTRITION AND DIET THERAPY Mezzanine, Pantlind Hotel	Wednesday, September 27	9:00 a.m. – adjournment
	Thursday, September 28	9:00 a.m. – adjournment

GENERAL INFORMATION

MSMS OFFICE – Vandenberg Room, Civic Auditorium

Hours: 8:00 a.m. to 5:00 p.m., each day.

MSMS MESSAGE CENTER – Main Lobby, Civic Auditorium.

Special lines will be installed for local and long distance telephone calls for registrants and exhibitors at the MSMS meeting. The telephone numbers are: Area Code 616 456-5363 and 456-5364. CHECK THE MESSAGE CENTER BOARD REGULARLY FOR POSTED MESSAGES.

ANNUAL SESSION PROGRAM COMMITTEE

Harry A. Towsley, MD, Chairman, Ann Arbor; G. Thomas McKean, MD, Vice-Chairman, Detroit; W. C. Baum, MD, Grand Rapids; K. H. Johnson, MD, Lansing; R. L. Rapport, MD, Flint; F. P. Rhoades, MD, Detroit, and S. B. Winslow, MD, Battle Creek.

ANNUAL SESSION NEWS COMMITTEE

Howard G. Benjamin, MD; John L. Doyle, MD; Paul W. Kniskern, MD; Joseph R. Lentini, MD; and James P. Muldoon, MD, all of Grand Rapids; and Claude L. Weston, MD, Owosso, Member Emeritus.

MSMS NEWS ROOM – Room F, Civic Auditorium

Hours: 8:00 a.m. to 5:00 p.m., each day.

GENERAL INFORMATION

TICKETS for the daily general luncheons, the Annual State Society Dinner Dance, and meal functions of related groups and sections will be available at the registration desk.

NO REGISTRATION FEE required for members of MSMS and other state medical associations, the AMA or the Canadian Medical Association.

ADMISSION to all meetings in the Civic Auditorium and to the exhibits will be by badge only. Please present MSMS, other state medical association, AMA, or CMA membership card to expedite registration. This will save your time.

Interns, residents, medical students, and nurses are welcome to attend the scientific meetings.

PARKING. Two municipal lots and a parking ramp are located within easy walking distance of the Civic Auditorium at a nominal charge. Free parking is available at Pantlind Hotel for overnight guests. Doorman can direct you to the Hotel lot.

ART SHOW. All registrants at the Annual Session are invited to visit the 1967 Art Show in the Main Lobby of the Civic Auditorium. Open to all physicians and their wives, the Show can be viewed at the following times:

Wednesday, September 27	8:15 a.m. — 5:30 p.m.
Thursday, September 28	8:15 a.m. — 5:30 p.m.
Friday, September 29	8:15 a.m. — 12:30 p.m.

This project is sponsored by the Woman's Auxiliary to the Michigan State Medical Society.

DAILY GENERAL LUNCHEON for all registrants and speakers on Wednesday, Thursday and Friday is available in the lower level of the Civic Auditorium. Tickets may be purchased at the registration desk. The Cash bar and the luncheon area is open noon — 2:00 p.m.

COFFEE BREAK and **INTERMISSION TO VIEW THE EXHIBITS** on Wednesday and Thursday is 10:00 — 10:45 a.m. and 3:15 — 4:15 p.m.; on Friday, 10:00 — 10:45 a.m. Coffee will be served in the Exhibit Hall.

PAPERS WILL BEGIN AND END ON TIME — Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time in accordance with the programed schedule. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and attending accordingly.

NEW INFORMATION IN THE EXHIBIT

MSMS is proud to present an outstanding scientific and technical exhibit at its 102nd Annual Session.

All physicians are urged to visit the educational displays, to take advantage of the new information available, and also to express appreciation for the exhibitors' contributions to the MSMS postgraduate program.

ANNUAL SCIENTIFIC SESSION PROGRAM

CIVIC AUDITORIUM

WEDNESDAY MORNING, SEPTEMBER 27

CHOOSE FROM THREE CONCURRENT SESSIONS*

8:45 - 10:00

BLACK & SILVER ROOM

Groups Cooperating:

MSMS Section on Internal Medicine

Michigan Heart Association

Comprehensive Care in Coronary Artery Disease *(Symposium)*

Moderator — Park W. Willis, MD, Professor of Internal Medicine, University of Michigan Medical School

Preventions Coping with Risk Factors

William B. Kannel, MD, Director of Framingham Heart Study, Framingham, Massachusetts

Medical Management

Keith H. Averill, MD, Director, Cardiovascular Department, Research Hospital and Medical Center, Kansas City, Missouri

Evaluating the Coronary Circulation: Does "Revascularization" Help?

Harvey G. Kemp, MD, Peter Bent Brigham Hospital, Boston

Heart Revascularization — Rationale and Results

William H. Sewell, MD, Chief, Cardiac Surgery, Guthrie Clinic, Sayre, Pennsylvania

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ROOM C

MSMS Committee Cooperating:

Maternal Health

Abortion — Pro and Con *(Symposium)*

Moderator: J. Robert Willson, MD, Professor of Obstetrics and Gynecology, University of Michigan School of Medicine

B. James George, Jr., A.B., J.D., Professor of Law, University of Michigan Law School

Sprague H. Gardiner, MD, Professor of Obstetrics and Gynecology, University of Indiana Medical School

---

ROOM D

MSMS Committee

Cooperating: Education Liaison

Paramedical Personnel — Extra Hands for the Doctor

Moderator: Harold J. Meier, MD, Chairman, MSMS Committee on Paramedical Education, Coldwater

William G. Birch, MD, Kalamazoo

Robert E. Kinsinger, PhD, W. K. Kellogg Foundation, Battle Creek

Don Marshall, MD, Chairman, MSMS Committee on Education Liaison, Kalamazoo

---

10:00 - 10:45

Coffee Break and Intermission to View the Exhibits

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*See Page 1217 for the continuous Curbstone Consultations Wednesday morning.

Continued: WEDNESDAY MORNING

10:45 - 12:00

CHOOSE FROM THREE CONCURRENT SESSIONS

BLACK & SILVER ROOM

Groups Cooperating:
MSMS Section on Internal Medicine
Michigan Heart Association

Comprehensive Care in Coronary Artery Disease *(Symposium continued)*

Moderator: Larry H. Birch, MD, Associate Professor of Internal Medicine, Department of Postgraduate Medicine, University of Michigan Medical School

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ROOM C

MSMS Section Cooperating:
Dermatology

Collagen Disease — Its Skin Manifestations *(Seminar)*

Moderator and Discussant: E. Richard Harrell, MD, Professor of Dermatology, University of Michigan Medical School

Thomas K. Burnham, MD, Associate Physician, Department of Dermatology, Henry Ford Hospital, Detroit

Charles G. Mendelson, MD, Henry Ford Hospital, Detroit

ROOM D

Groups Cooperating:
MSMS Section on Anesthesiology
Michigan Society of Anesthesiologists

Obstetrical Anesthesia *(Round Table Discussion)*

Frank Moya, MD, Professor and Chairman, Department of Anesthesiology, University of Miami School of Medicine, Florida

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SPECIAL FEATURE

9:00 - 12:00 and 2:00 - 5.00

RED ROOM

Curbstone Consultations

Paper Work and Governmental Medical Care Programs

Moderator: J. Kenneth Altland, MD, Medical Director, Department of Social Services, State of Michigan

Lee Forest, Regional Office, Social Security Administration, Chicago

James L. Hall, RP, Assistant to Director of Medical Services, Department of Social Services, State of Michigan

R. Bernard Houston, JD, Director, Department of Social Services, State of Michigan

G. P. Kearney, Michigan Blue Shield, Detroit

Anthony R. Ceresko, MD, Medical Coordinator, Division of Services to Handicapped Children, Michigan Department of Public Health, Detroit

Harold L. Tremain, MD, Michigan Blue Cross, Detroit

12:00 - 2:00

CIVIC AUDITORIUM
LOWER LEVEL

GENERAL LUNCHEON FOR ALL REGISTRANTS
WITH THE SPEAKERS OF THE DAY

WEDNESDAY AFTERNOON, SEPTEMBER 27

CHOOSE FROM THREE CONCURRENT SESSIONS

2:00 - 3:15

BLACK & SILVER ROOM

MSMS Sections Cooperating:

General Practice

Internal Medicine

Pediatrics

The New Physician *(Seminar)*

Moderator: Andrew D. Hunt, MD, Dean, College of Human Medicine, Michigan State University

The New Physician

William R. Willard, MD, Vice President, Medical Center, University of Kentucky

The Pitfalls of Implementing the New Physician

Richard M. Magraw, MD, Director, Comprehensive Clinic Program, University of Minnesota College of Medical Services

---

ROOM C

MSMS Sections Cooperating:

Allergy & Applied Immunology

General Practice

Internal Medicine

Pediatrics

Primary Immunologic Deficiency Diseases *(Seminar)*

Moderator: Kenneth P. Mathews, MD, Professor of Internal Medicine, University of Michigan

Raymond D. A. Peterson, MD, Associate Professor of Pediatrics, University of Chicago Medical School

Henry N. Claman, MD, Assistant Professor of Internal Medicine, University of Colorado Medical School *(Discussant)*

ROOM D

Groups Cooperating:

MSMS Committee on Alcoholism & Drug Addiction

MSMS Sections on
General Practice
Internal Medicine
Pediatrics

Drug Dependence *(Round Table Discussion)*

Herbert A. Raskin, MD, Clinical Associate Professor, Department of Psychology, Wayne State University School of Medicine

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3:15 - 4:15

Coffee Break and Intermission to View Exhibits

Continued: WEDNESDAY AFTERNOON

4:15 - 5:30

CHOOSE FROM THREE CONCURRENT SESSIONS

ACK & SILVER ROOM

MS Sections
operating:

neral Practice

ernal Medicine

iatrics

Regional Medical Plans for Heart, Cancer, and Stroke *(Seminar)*

Moderator: Don Marshall, MD, MSMS Representative to and Vice-President of the Michigan Association for Regional Medical Programs, Inc.

William N. Hubbard, Jr., MD, Dean, University of Michigan Medical School

James T. Howell, MD, Executive Director, Henry Ford Hospital, National Advisory Council for Regional Medical Programs, Detroit

A. E. Heustis, MD, Director-Designate, Michigan Association for Regional Medical Programs, Inc.

M C

MS Sections
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iatrics

Secondary Immunologic Deficiency Diseases *(Seminar)*

Moderator: Kenneth P. Mathews, MD, Professor of Internal Medicine, University of Michigan

Henry N. Claman, MD, Assistant Professor of Internal Medicine, University of Colorado Medical School

Raymond D. A. Peterson, MD, Associate Professor of Pediatrics, University of Chicago Medical School *(Discussant)*

M D

ups Cooperating:

MS Committee on
oholism &
g Addiction

MS Sections on
neral Practice
rnal Medicine
urology & Psychiatry
iatrics

Alcoholism — Recognizing a Medical Iceberg *(Round Table Discussion)*

Melvin L. Selzer, MD, Associate Professor of Psychiatry, University of Michigan Medical School

Donald L. Damstra, MD, Brighton Hospital, Michigan

MSMS GRATEFULLY ACKNOWLEDGES PROGRAM GRANTS FROM THE FOLLOWING:

- THE UPJOHN COMPANY
- WARNER-CHILCOTT LABORATORIES
- MICHIGAN CANCER COORDINATING COMMITTEE
- MICHIGAN HEART ASSOCIATION

THURSDAY MORNING, SEPTEMBER 28

CHOOSE FROM THREE CONCURRENT SESSIONS

8:45 - 10:00

BLACK & SILVER ROOM

MSMS Sections Cooperating:

General Practice

Gynecology & Obstetrics

Pediatrics

Emergencies in the Delivery Room *(Seminar)*

Moderator: T. N. Evans, MD, Professor and Chairman, Department of Obstetrics-Gynecology, Wayne State University School of Medicine

Obstetrician-Gynecologist

Frederick P. Zuspan, MD, Chief, Department of Obstetrics-Gynecology, University of Chicago

Pediatric Emergencies in the Delivery Room

Bruce D. Graham, MD, Children's Hospital, Columbus, Ohio

Anesthesiologist

Otto C. Phillips, MD, Pittsburgh

ROOM C

MSMS Section Cooperating:

Neurology & Psychiatry

Recognition and Management of the Suicidal Patient *(Seminar)*

Moderator: Kenneth E. Pitts, MD, Grosse Pointe

Viggo W. Jensen, MD, Grosse Pointe

Thomas A. Petty, MD, Grosse Pointe

ROOM D

MSMS Section Cooperating:

Occupational Medicine

Medical Intelligence Systems — Computer Oriented *(Round Table Discussion)*

W. T. Stille, Medical Department, Eastman Kodak Company, Rochester, New York

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10:00 - 10:45

Coffee Break and Intermission to View Exhibits

Continued: THURSDAY MORNING

10:45 - 12:00

CHOOSE FROM FOUR CONCURRENT SESSIONS

BLACK & SILVER ROOM

MSMS Section Cooperating:

General Practice

The Use and Abuse of Common Therapeutic Agents *(Seminar)*

Moderator: Francis P. Rhoades, MD, Chairman, Michigan Academy of General Practice Scientific Assembly, Detroit

Edward A. Carr, MD, Professor of Pharmacology and Associate Professor of Internal Medicine, University of Michigan Medical School, and Director, Upjohn Center for Clinical Pharmacology, Ann Arbor

F. Robert Fekety, Jr., MD, Assistant Professor of Medicine, Johns Hopkins Hospital, Baltimore

Lawrence Power, MD, Associate Professor of Medicine and Chief, Endocrinology and Metabolism, Wayne State University School of Medicine

---

ROOM C

MSMS Sections Cooperating:

Orthopedic Surgery

Pediatrics

Common Foot Problems in Children *(Round Table Discussion)*

Nicholas J. Giannestras, MD, Assistant Clinical Professor, Orthopaedic Division, Department of Surgery, University of Cincinnati School of Medicine, Cincinnati

---

ROOM D

Groups Cooperating:

MSMS Section on Surgery

Michigan Cancer Coordinating Committee

Carcinoma of the Esophagus — Radiation vs. Surgery *(Seminar)*

Moderator: Joseph A. Witter, MD, Head of Department of Surgery, Highland Park General Hospital, Michigan

Herbert D. Adams, MD, Department of General Surgery, Lahey Clinic Foundation, Boston

Isadore Lampe, MD, Professor of Radiology, University of Michigan Medical School

---

RED ROOM

MSMS Committee Cooperating:

Education Liaison

Paramedical Personnel — Extra Hands for the Doctor *(Discussion)*

Moderator: Harold J. Meier, MD, Chairman, MSMS Committee on Paramedical Education, Coldwater

William G. Birch, MD, Kalamazoo

Robert E. Kinsinger, PhD, W. K. Kellogg Foundation, Battle Creek

Don Marshall, MD, Chairman, MSMS Committee on Education Liaison, Kalamazoo

---

12:00 - 2:00

CIVIC AUDITORIUM
LOWER LEVEL

GENERAL LUNCHEON FOR ALL REGISTRANTS
WITH THE SPEAKERS OF THE DAY

THURSDAY AFTERNOON, SEPTEMBER 28

CHOOSE FROM FOUR CONCURRENT SESSIONS

2:00 - 3:15

BLACK & SILVER ROOM

MSMS Sections Cooperating:

Neurological Surgery

Orthopedic Surgery

Surgery

Urology

Surgical Emergencies *(Symposium)*

Moderator: Alexander J. Walt, MD, Assistant Dean, Professor and Chai man, Department of Surgery, Wayne State University School of Medicin

Emergency Surgery in Children

H. William Clatworthy, MD, Professor and Chief, Department of Ped atric Surgery, Children's Hospital, Columbus, Ohio

Orthopedic Surgery

William S. Smith, MD, Professor of Surgery and Head of Orthopedic University of Michigan Medical School

Cardiac Shock

Robert F. Wilson, MD, Receiving Hospital, Detroit

Neurological Surgery

A. Earl Walker, MD, Professor of Neurological Surgery, Johns Hopkin Hospital, Baltimore

Urological Surgery

James M. Pierce, MD, Wayne State University School of Medicine

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ROOM C

MSMS Section Cooperating:

Plastic Surgery

Decision Between Radiation and Surgery in Treatment of Cancer of the Head and Neck *(Round Table Discussion)*

S. Stanley Hoffmeister, MD, Roswell Park Memorial Institute, Buffalo

---

ROOM D

Groups Cooperating:

MSMS Section on Public Health & Preventive Medicine

MSMS Committee on Venereal Disease Control

Venereal Disease on the Rampage and What You Can Do about It *(Seminar)*

Moderator: Arthur C. Curtis, MD, Professor and Chairman, Department of Dermatology, University of Michigan Medical School

Joseph C. Cerny, MD, Assistant Professor of Surgery, University of Michigan Medical School

Benjamin Schwimmer, MD, Director of Social Hygiene Clinic, Detroit Health Department

---

RED ROOM

MSMS Section Cooperating:

Otolaryngology

Facial Trauma *(Round Table Discussion)*

John T. Dickinson, MD, Associate Clinical Professor of Otolaryngology, Mercy Hospital, Pittsburgh

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3:15 - 4:15

Coffee Break and Intermission to View the Exhibits

Continued: THURSDAY AFTERNOON

4:15 - 5:30

CHOOSE FROM FOUR CONCURRENT SESSIONS

BLACK & SILVER ROOM	Surgical Emergencies *(Symposium continued)*
ROOM C MSMS Section Cooperating: Obstetrics & Gynecology	Thoughts about Toxemia of Pregnancy *(Round Table Discussion)* Frederick P. Zuspan, MD, Chief of the Department of Obstetrics- Gynecology, University of Chicago Medical School
ROOM D MSMS Section Cooperating: Proctology	Rectal Bleeding *(Seminar)* Moderator: Don W. McLean, MD, Detroit Howard G. Benjamin, MD, Grand Rapids George T. Bradley, MD, Detroit Maus W. Stearns, MD, New York City
RED ROOM Groups Cooperating: MSMS Section on Ophthalmology Michigan Ophthalmological Society	Naso-orbital Fractures and Traumatic Deformities of the Medical Canthus *(Round Table Discussion)* William C. Grabb, MD, Assistant Professor of Surgery, Section of Plastic Surgery, University of Michigan Medical School

THURSDAY EVENING, SEPTEMBER 28

8:00

BALLROOM PANTLIND HOTEL Groups Cooperating: MSMS Section on Public Health & Preventive Medicine MSMS Committee on Maternal Health	*Family Life and Sex Education — Neglect or Overemphasis *(Public Forum)* Esther D. Schulz, PhD, RN, Associate Director for Education Services, Sex Information Council of the United States, New York City Chairman: Robert E. Rowe, MD, Port Huron Secretary: Eleanor P. Skufis, MD, Adrian **(The special evening program is open to teachers, ministers, social workers, youth leaders and others interested in the vital topic.)*

FRIDAY MORNING, SEPTEMBER 29

CHOOSE FROM THREE CONCURRENT SESSIONS

8:45 - 10:00

BLACK & SILVER ROOM

MSMS Section Cooperating:

Pediatrics

Controversies in the Management of Children — The Tonsil Problem, When to Open Ears, Urinary Infection *(Seminar)*

Moderator: Paul V. Woolley, MD, Pediatrician-in-Chief, Children's Hospital of Michigan, Detroit

William J. Oliver, MD, Professor and Chairman, Department of Pediatrics, University of Michigan Medical School

Walter P. Work, MD, Professor and Chairman, Department of Otorhinolaryngology, University of Michigan Medical School

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ROOM C

MSMS Section Cooperating:

Gastroenterology

The Management of Portal Hypertension *(Round Table Discussion)*

Moderator: Bernard M. Schuman, MD, Associate Physician, Division of Gastroenterology, Henry Ford Hospital, Detroit

Charles G. Child, III, MD, Professor and Chairman, Department of Surgery, University of Michigan Medical School

Benjamin H. Sullivan, MD, Staff Member, Department of Gastroenterology, Cleveland Clinic, Cleveland

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ROOM D

Groups Cooperating:

MSMS Section on Gynecology & Obstetrics

MSMS Committee on Maternal Health

What's Good and What's Bad With The Newer Contraceptives *(Round Table Discussion)*

Moderator: Harrison C. Visscher, MD, Grand Rapids

Wm. J. Ledger, MD, Ann Arbor

Darrell E. Statzer, MD, Detroit

10:00 - 10:45

Coffee Break and Intermission to View the Exhibits

Continued: FRIDAY MORNING

10:45 - 12:00

CHOOSE FROM THREE CONCURRENT SESSIONS

BLACK & SILVER ROOM
MSMS Section Cooperating:
Pediatrics

The Management of Common Pediatric Problems *(Pediatric Clinical Conference)*

Moderator: Paul V. Woolley, MD, Pediatrician-in-Chief, Children's Hospital of Michigan, Detroit

Bruce D. Graham, MD, Professor and Chairman, Department of Pediatrics, College of Medicine, Ohio State University

William J. Oliver, MD, Professor and Chairman, Department of Pediatrics, University of Michigan Medical School

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ROOM C
MSMS Section Cooperating:
Gastroenterology

The Use of the Gastro-Camera *(Wet Clinic)*

Robert J. Priest, MD, Physician-in-Charge, Division of Gastroenterology, Henry Ford Hospital, Detroit

Benjamin H. Sullivan, MD, Staff Member, Department of Gastroenterology, Cleveland Clinic, Cleveland

Daniel Joseph Fall, MD, Instructor in Internal Medicine, University of Michigan Medical School

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ROOM D
MSMS Section Cooperating:
Radiology

Gross Rates of Colonic Polyps and Carcinoma *(Round Table Discussion)*

Leo S. Figiel, MD, Detroit
Steven J. Figiel, MD, Detroit

12:00 - 2:00

CIVIC AUDITORIUM
LOWER LEVEL

GENERAL LUNCHEON FOR ALL REGISTRANTS
WITH THE SPEAKERS OF THE DAY

ADJOURNMENT

SECTION BUSINESS MEETINGS

Physicians are invited to attend the section meetings of their specialty interests.

ALLERGY AND APPLIED IMMUNOLOGY: Wednesday, September 27, Room C, Civic Auditorium, 3:45 p.m.

ANESTHESIOLOGY and the Michigan Society of Anesthesiologists, Inc.: Wednesday, September 27, Room D, Civic Auditorium, 11:45 a.m.

DERMATOLOGY: Wednesday, September 27, Room C, Civic Auditorium, 11:45 a.m.

GASTROENTEROLOGY: Friday, September 29, Room C, Civic Auditorium, 11:45 a.m.

GENERAL PRACTICE: Thursday, September 28, Black and Silver Room, Civic Auditorium, 11:45 a.m.

INTERNAL MEDICINE: Wednesday, September 27, Black and Silver Room, Civic Auditorium, 11:45 a.m.

NEUROLOGICAL SURGERY and the Michigan Association of Neurological Surgeons: Thursday, September 28, 6:00 p.m. dinner meeting, Lakos Restaurant. (Send reservations to A. E. Lamberts, MD, 68 Ransom Avenue, Northeast, Grand Rapids 48502.)

OBSTETRICS AND GYNECOLOGY: Thursday, September 28, Room C, Civic Auditorium, 5:15 p.m.

OCCUPATIONAL MEDICINE: Thursday, September 28, Room D, Civic Auditorium, 9:45 a.m.

OPHTHALOMOLOGY and the Michigan Ophthalmological Society: Thursday, September 28, Red Room, Civic Auditorium, 5:15 p.m. A reception following the meeting will be held in the Pantlind Hotel.

OTOLARYNGOLOGY: Thursday, September 28, Red Room, Civic Auditorium, 3:00 p.m.

ORTHOPEDIC SURGERY and the Michigan Ortropaedic Society: Thursday, September 28, 5:00 p.m. reception-dinner meeting in the Pantlind Hotel.

PATHOLOGY: no meeting in 1967.

PEDIATRICS and the Michigan Branch of the American Academy of Pediatrics: Thursday, September 28, 6:00 p.m. reception-dinner meeting, Peninsular Club. The pre-prandial and dinner are both given by the courtesy of Gerber Products of Fremont. (Send reservations to J. R. Wilson, MD, 1033 Fulton West, Grand Rapids 49504.)

PLASTIC SURGERY: Thursday, September 28, Room C, Civic Auditorium, 3:00 p.m.

PROCTOLOGY: Thursday, September 28, Room D, Civic Auditorium, 5:15 p.m.

PSYCHIATRY AND NEUROLOGY and the Michigan Society of Psychiatry and Neurology: Thursday, September 28, 6:00 p.m. dinner meeting in the Pantlind Hotel. (Send reservations to Sanford Bloomberg, MD, 23023 Orchard Lake Road, Farmington 48024.)

PUBLIC HEALTH AND PREVENTIVE MEDICINE: Thursday, September 28, Room D, Civic Auditorium, 3:00 p.m. A reception following the meeting will be held in the Pantlind Hotel.

RADIOLOGY: Friday, September 29, Room D, Civic Auditorium, 11:45 a.m.

SURGERY: Thursday, September 28, Room D, Civic Auditorium, 11:45 a.m.

UROLOGY: no meeting in 1967.

SCIENTIFIC SECTION OFFICERS

Allergy and Applied Immunology
Chairman: Norman W. Brey, MD, Detroit
Vice-Chairman: Julius J. Greenberg, MD, Detroit
Secretary: Jack E. Goodwin, MD, Saginaw
Treasurer: John M. Lesesne, MD, Grosse Pointe

Anesthesiology
Chairman: Albertus J. Hoffs, MD, Grand Rapids
Vice-Chairman: Shirley Austin, MD, Belleville
Secretary: Ralph E. Bauer, MD, Detroit

Dermatology
Chairman: Robert E. Burns, MD, Detroit
Secretary: Ralph J. Coskey, MD, Oak Park

Gastroenterology
Chairman: Bernard M. Schuman, MD, Detroit
Secretary: William G. O'Driscoll, MD, Grand Rapids

General Practice
Chairman: Clare C. Huggett, MD, Lansing
Secretary: John W. Battle, MD, Dearborn

Internal Medicine
Chairman: Beverly C. Payne, MD, Ann Arbor
Secretary: John B. Bryan, MD, Royal Oak

Michigan Association of Neurological Surgeons (Section on Neurological Surgery)
Chairman: Austin E. Lamberts, MD, Grand Rapids
Vice-Chairman: John R. Williams, MD, Grand Rapids
Secretary: Philip J. Huber, MD, Detroit

Obstetrics and Gynecology
Chairman: Charles W. Aldridge, MD, Grand Rapids
Secretary: John P. Ottaway, MD, Grosse Pointe Farms

Occupational Medicine
Chairman: Frank G. Talbot, MD, Detroit
Secretary: Richard W. Prior, MD, Flint

Opthalmology
Chairman: Robert T. Blackhurst, MD, Midland
Secretary: James L. Frey, MD, Detroit

Otolaryngology
Chairman: Robert D. Burton, MD, Grand Rapids
Secretary: Paul Dzul, MD, Detroit

Orthopedic Surgery
Chairman: James A. MacDonell, MD, Grand Rapids
Vice-Chairman: Curtis M. Hanson, MD, Kalamazoo
Secretary: George D. Stilwill, MD, Lansing

Pathology
Chairman: John R. McDonald, MD, Detroit
Vice-Chairman: Harold E. Bowman, MD, Grand Rapids
Secretary: Edwin M. Knights, Jr., MD, Southfield

Pediatrics
Chairman: John R. Wilson, MD, Grand Rapids
Vice-Chairman: John L. Doyle, MD, Grand Rapids
Secretary: Anthony C. Gholz, MD, Port Huron

Plastic Surgery
Chairman: William A. Lange, MD, Detroit
Vice-Chairman: William G. Yost, Jr., MD, Grand Rapids
Secretary: Robert Pool, Jr., MD, Birmingham

Proctology
Chairman: George L. Walker, MD, Detroit
Secretary: George Kinsley, MD, Pontiac

Psychiatry and Neurology
Chairman: Kenneth E. Pitts, MD, Grosse Pointe
Secretary: Glen G. Golloway, MD, Ann Arbor

Public Health and Preventive Medicine
Chairman: Robert E. Rowe, MD, Port Huron
Vice-Chairman: Gordon A. Eadie, MD, Newberry
Secretary: Eleanor P. Skufis, MD, Adrian

Radiology
Chairman: Leo S. Figiel, MD, Grosse Pointe
Vice-Chairman: Robert S. Ormond, MD, Dearborn
Secretary: Victor Curatolo, MD, Mt. Clemens

Surgery
Chairman: Robert O. Northway, MD, Saginaw
Secretary: Joseph A. Witter, MD, Highland Park

Urology
Chairman: Robert C. Thumann, MD, Grosse Pointe Woods
Vice-Chairman: Edward J. Shumaker, MD, Detroit
Secretary: James M. Pierce, Jr., MD, Detroit

MEETINGS OF RELATED GROUPS

WOMAN'S AUXILIARY CONVENTION: Tuesday through Thursday, September 26-28, Pantlind Hotel.

FIFTH ANNUAL CONFERENCE ON NUTRITION AND DIET THERAPY: Wednesday and Thursday, September 27-28, Pantlind Hotel.

MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY CONVENTION: Tuesday through Thursday, September 26-28, Morton House.

ALUMNI GROUPS:

The University of Michigan Medical Center Alumni Society cordially invites alumni and friends to its Hospitality Suite in the Pantlind Hotel during the MSMS meeting. The Suite will be open Sunday afternoon, September 24, through Thursday, September 28.

The Wayne State University School of Medicine Alumni Association will have a Hospitality Suite at the Pantlind Hotel. A special reception for all alumni, faculty, and friends will be held on Wednesday, September 27, from 4:00 to 6:00 p.m. Representatives of the University will attend. The Headquarters Suite will be maintained Tuesday, September 26, through Thursday, September 28, 11:00 a.m. to 6:00 p.m.

The Vanderbilt Alumni Association will hold a reception on Wednesday, September 27, from 6:00 to 7:00 p.m. in the Pantlind Hotel. All members and their wives are invited.

The University of Pennsylvania Medical Alumni will hold a reception Thursday, September 28, from 6:00 to 8:00 p.m. in the Pantlind Hotel.

Wednesday, September 27

MDPAC BREAKFAST: 7:30 a.m., breakfast meeting, Pantlind Hotel. Tickets can be secured in advance by contacting the MDPAC Office, P.O. Box 169, East Lansing 48823. Cost is $2.00. The speaker is Minority Leader of the United States House of Representatives, Congressman Gerald Ford.

MSMS COMMITTEE ON INTERNATIONAL HEALTH: 2:00 to 5:00 p.m., Pantlind Hotel. The Committee will be available in one of the large suites to confer with physicians who are interested in possible short-term assignments for foreign medical work. The suite number will be posted on the Hotel bulletin board.

Thursday, September 28

MICHIGAN BRANCH, AMERICAN ACADEMY OF PEDIATRICS AND THE MSMS SECTION ON PEDIATRICS: 6:00 p.m. reception and dinner meeting, Peninsular Club. The pre-prandial and dinner are both given by the courtesy of Gerber Products of Fremont. Obtain your reservation from J. R. Wilson, MD, 1033 Fulton West, Grand Rapids 49504. The speaker is H. William Clatworthy, MD, Professor and Chief, Department of Pediatric Surgery at Children's Hospital, Columbus, Ohio, on the subject "Diagnosis and Management of Diseases of the Liver, Bile Duct, and Portal System in Infants and Children."

MICHIGAN SOCIETY OF PSYCHIATRY AND NEUROLOGY: 3:00 to 6:00 p.m. meeting of the Council, Pantlind Hotel.

MICHIGAN SOCIETY OF PSYCHIATRY AND NEUROLOGY AND THE MSMS SECTION ON PSYCHIATRY AND NEUROLOGY: 6:00 p.m. reception and dinner meeting, Pantlind Hotel. Reservations may be obtained from Sanford Bloomberg, MD, Chairman of the Arrangements Committee, 23023 Orchard Lake Road, Farmington 48024. The meeting will end in time to attend the 8:00 p.m. seminar on "Family Life and Sex Education—Neglect or Overemphasis" in the Ballroom of the Pantlind Hotel. The speaker at this meeting is Esther D. Schulz, PhD, RN, Associate Director for Education Services, Sex Information Education Council of the United States, New York.

MICHIGAN ORTHOPAEDIC SOCIETY AND THE MSMS SECTION ON ORTHOPEDIC SURGERY: 5:00 p.m. reception and dinner meeting, Pantlind Hotel. Reservations may be obtained from George D. Stilwill, MD, 2909 E. Grand River, Lansing 48912. The speaker is Nicholas J. Giannestras, MD, Assistant Clinical Professor, Orthopaedic Division, Department of Surgery, University of Cincinnati School of Medicine, on the subject "Surgical Correction of Flat Feet in the Adolescent." All Annual Session registrants are invited.

HEALTH CAREERS MOBILE ON EXHIBIT

The Health Careers Mobile will be on exhibit in Grand Rapids during the MSMS Annual Session for physicians, wives, medical assistants, nurses and others to view. The mobile unit was launched at the MSMS Centennial Session in Detroit in 1965 and toured the state during the first year with exhibits geared to 100 years of medical service to Michigan. During the past year, the unit has been re-christened as the "Health Careers Mobile" under the direction of the Michigan Health Council. Most of the exhibits have been replaced to appeal to young people, and adults, to consider careers in medicine and the health field. MSMS is a major financial supporter for the careers mobile unit.

MSMS Annual Session Dates

1968—Detroit, September 22-27

1969—Detroit, September 28-October 3

1970—Detroit, September 20-25

1971—Grand Rapids, October 3-8

1972—Detroit, September 24-29

TECHNICAL EXHIBITORS

(Numerical Listing)

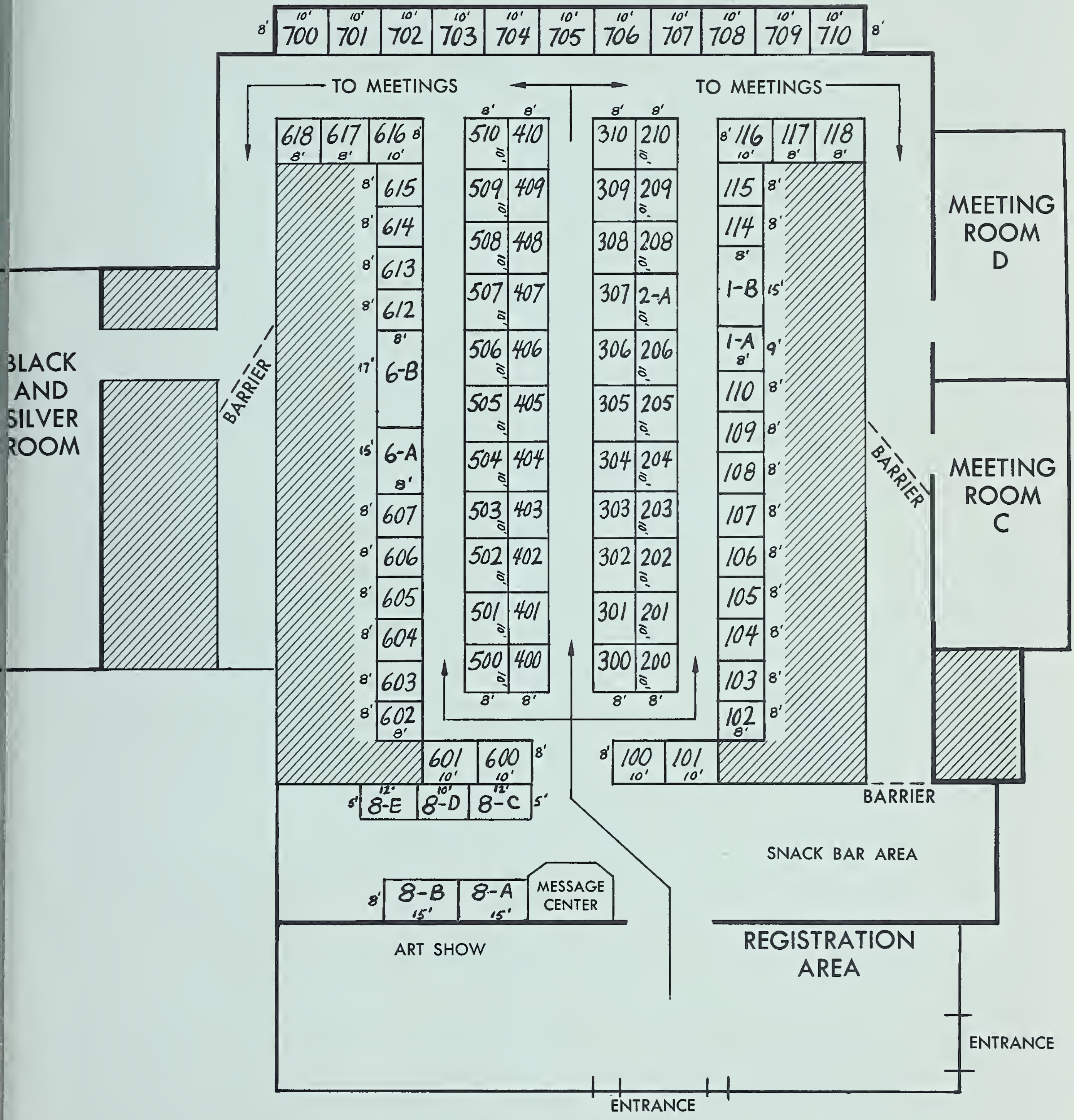
100	W. B. Saunders Company
101	Seven-Up Bottling Company of Western Michigan
102	Seven-Up Bottling Company of Western Michigan
103	Ortho Pharmaceutical Corporation
104	Black and Skaggs, Professional Management
105	Carnation Company
106	Encyclopaedia Britannica
107	Fellows-Testagar
108	Flint Laboratories, Inc.
109	William H. Rorer, Inc.
110	Meyer Laboratories, Inc.
114	Thomas A. Edison Industries
115	Sandoz Pharmaceuticals
116	Winthrop Laboratories, Inc.
117	Key Pharmaceuticals
118	U. S. Vitamin and Pharmaceutical Corporation
200	Ortho Pharmaceutical Corporation
201	J. B. Lippincott Company
202	North States Aviation
203	American Health Credit Plan of Michigan, Inc.
204	Barry Laboratories, Inc.
205	Creative Systems, Inc.
206	Hack Shoe Company, Inc.
208	Dow Chemical Company
209	Sherman Laboratories
210	Ferndale Laboratories, Inc.
300	Michigan Bell Telephone Company
301	Michigan Bell Telephone Company
302	G. D. Searle and Company
303	Abbott Laboratories
304	Rollins Shoes, Inc.
305	Ames Company, Inc.
306	Borden Company
307	Alta Supply Company
308	Commercial Equipment Company
309	Roche Laboratories
310	Gerber Products
400	Parke, Davis and Company
401	Parke, Davis and Company
402	Wyeth Laboratories
403	Stuart Company
404	Hoechst Pharmaceuticals, Inc.
405	Astra Pharmaceutical Products, Inc.
406	U. S. Tobacco Company
407	Michigan Medical Service
408	Siemens Medical of America, Inc.
409	Marion Laboratories
410	Lederle Laboratories
500	Smith Kline and French Laboratories
501	Merck Sharp and Dohme
502	Westwood Pharmaceuticals
503	Ross Laboratories
504	Beecham Research Laboratories
505	Wallace Laboratories
506	Loma Linda Food Company
507	Ben P. Stratton Agency, Inc.
508	Wynn Pharmaceuticals, Inc.
509	Warren-Teed Products Company
510	Mead Johnson Laboratories
600	E. R. Squibb and Sons
601	Coca Cola Company
602	Coca Cola Company
603	Medical Protective Company
604	Ayerst Laboratories
605	Eaton Laboratories
606	Syntex Laboratories, Inc.
607	Michigan Association of Collection Agencies
612	Union Bank and Trust Company
613	Medco Products Company
614	North American Pharmacal
615	Borcherdt Company
616	Eli Lilly and Company
617	W-T-S Pharmacraft
618	P. Lorillard Company
700	S. J. Tutag and Company
701	Len-Tag Company
702	Marshall Erdman and Associates
703	Ciba Pharmaceutical Products, Inc.
704	Geigy Pharmaceutical
705	Schering Corporation
706	A. H. Robins Company, Inc.
707	Pet Milk Company
708	Bristol Laboratories
709	American Surgical Trade Association — District VI
710	R. J. Reynolds Tobacco Company

SCIENTIFIC EXHIBITS

(Numerical Listing)

1-A	"Epiphyseal Injuries"
1-B	"Improving the End Bearing Characteristics of Lower Extremity Amputation Stumps by the Use of Silicone Rubber Implants"
2-A	"Chronic Dialysis Program"
6-A	"A New Method of Measuring Myocardial Blood Flow in Man"
6-B	"Insure Femaleness-Control Conception"
8-A	"Alcoholism Is Your Business"
8-B	"Dose Response: Key to Effective Treatment"
8-C	"Clinical Application of Physical Therapy Modalities"
8-D	"Management of the Multiple Sclerosis Patient"
8-E	"Surgery of the Arthritis Foot"

GUIDE TO MEETING ROOMS AND EXHIBITS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MESSAGE CENTER
BLACK AND SILVER ROOM
BARRIER
BARRIER
BARRIER
MEETING ROOM D
MEETING ROOM C
SNACK BAR AREA
ART SHOW
REGISTRATION AREA
ENTRANCE
ENTRANCE

Civic Auditorium Floor Plan
All Activities Concentrated on Main Floor

MSMS TECHNICAL EXHIBIT DESCRIPTIONS

Abbott Laboratories
North Chicago, Ill. — No. 303

Abbott Laboratories will feature the following products: Erythrocin®, an antibiotic of unparalled safety and known bactericidal action against many common pathogens. Also to be shown is a selection of antihypertensive "Building Block" products covering treatment of the full spectrum of benign essential hypertension, from mild to moderate to severe.

Alta Supply Company
(Formerly C. J. Rouser Supply Co.)
Lansing, Mich. — No. 307

Technicians will be available at our booth to discuss new developments in Pulmonary Therapy which we install in the Doctor's Office, the Hospital, and in the Patient's home. See and discuss Bird Respirators and controls, therapy and emergency equipment, Jones Pulmonors for testing, Mistogen, Air Shields, DeVilbiss, Ohio, Dupaco, and Bard. Twenty-four hour emergency service available.

American Health Credit Plan of Michigan, Inc.
Battle Creek, Mich. — No. 203

American Surgical Trade Association
District VI — No. 709

The American Surgical Trade Association booth is sponsored by District VI of the A.S.T.A. The dealers participating in this exhibit are listed at the booth and all are pleased to be a part of your convention. Doctors who wish to make contact with a company representative may register with the booth attendant.

Ames Company
Elkhart, Ind. — No. 305

Ames Company will feature LABSTIX — A urine screening agent; DEXTROSTIX — a 60-second test for blood glucose levels; GLUCOLA — a carbonated preparation for glucose tolerance tests, and additional diagnostic aids. ULTRADOP a new ultrasonic Doppler instrument for detection of fetal heart motion will also be shown.

Astra Pharmaceutical Products, Inc.
Worcester, Mass. — No. 405

Information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (prilocaine) local and topical anesthetics, and iron preparations Astrafer® (dextriferron) for intravenous use and Jectofer® (iron sorbitex) for intramuscular administration will be available at the Astra booth.

Ayerst Laboratories
New York, N. Y. — No. 604

Ayerst Laboratories extends an invitation to visit our display located in space 604 where Atromid-S and Premarin are being featured. Our representatives will be pleased to discuss these or other Ayerst products with you.

Barry Laboratories, Inc.
Detroit, Mich. — No. 204

Allergy products for diagnosis and treatment. Please stop to talk to us about the new Sensi-System — as easy as 1-2-3.

Insect Antigen No. 108 — Prophylactic treatment for patients who have had severe reactions to bites of stinging insects.

Beecham Research Laboratories
New York, N. Y. — No. 504

You are cordially invited to visit our exhibit featuring PENBRITIN (ampicillin), the new semi-synthetic broad-spectrum penicillin for wider use in major areas of infection.

Ayerst Laboratories, distributors
for
Beecham Research Laboratories, Inc.

Black & Skaggs Associates, Inc.
Professional Management
Battle Creek, Mich. — No. 104

PROFESSIONAL MANAGEMENT • FOR PHYSICIANS AND DENTISTS
since 1932
PM®

Professional Management
A Complete Business
Service For The
Medical Profession.

The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc. of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of the oldest and largest such firm in the country are at their command. Those in attendance at the MSMS Convention are cordially invited to stop at Booth No. 104 and meet the experienced PM Executives there.

Borcherdt Company
Chicago, Ill. — No. 615

Borcherdt's are featuring:

MALTSUPEX® Liquid, Powder and Tablets: Maltsupex, an extract of barley acts on the intestinal flora to produce a predominantly aciduric flora. Very useful dietary aid for chronic constipation in patients of all ages. Valuable in intractable pruritus ani and bowel upsets following antibiotic therapy.

SYLLAMALT®: Syllamalt is Maltsupex with added highly refined psyllium. Provides gentle bulking action in addition to stool softening properties. Syllamalt works better and tastes better than plain bulks.

FERROMALT® TABLETS: A combination of Ferrous Sulfate, and Maltsupex. Good clinical response without usual side effects of oral iron. Ferromalt Tablets are non-constipating, inexpensive and well tolerated.

Register for a Parker Pen. Requested samples will be mailed to your office.

The Borden Company
New York, N. Y. — No. 306

The Borden Company cordially invites you to visit our booth and be introduced to NEO-MULL-SOY the newest development for the feeding of infants allergic to cow's milk. Information on the composition and application of this milk substitute will be available, as well as up-to-date facts on BREMIL, MULL-SOY and METHAKOTE.

Bristol Laboratories
Syracuse, N. Y. — No. 708

Carnation Company
Los Angeles, Calif. — No. 105

Carnation Company cordially invites you to visit Booth 105, where Medical Representatives will be pleased to welcome members and guests of the Michigan State Medical Society.

OPTIMIL, Carnations new Infant Formula, will be featured. Complete information concerning this new product will be available.

Ciba Pharmaceutical Company
Summit, N. J. **No. 703**

CIBA Professional Service Representatives will be pleased to discuss Ser-Ap-Es.

Coca Cola Company
Atlanta, Ga. **Nos. 601-602**

Ice Cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Michigan, and The Coca-Cola Company.

Commercial Equipment Company
Grand Rapids, Mich. **No. 308**

A display of 3M equipment designed for the professional office. Applications to be demonstrated cover monthly statement preparation and background music.

Creative Systems, Inc.
Detroit, Mich. **No. 205**

A complete line of pegboard accounting forms — accounts receivable, checkwriting, and accounts payable. Micro Filming and statement machines for sending out statements.

The Dow Chemical Company
Midland, Mich. **No. 208**

A new diagnostic system developed in conjunction with Bio-Science Laboratories for doing blood chemistry tests will be shown. The tests provide a convenient, accurate method for doing hemoglobin, glucose, urea nitrogen, cholesterol and uric acid determinations photometrically.

Eaton Laboratories
Division of Norwich Pharmacal Company
Norwich, N. Y. **No. 605**

Since 1939, Eaton Laboratories has pioneered in the development of the nitrofurans, many of which have been available as legend drugs to the profession. Basic and clinical research is continuing on these as well as other classes of compounds.

In addition, Eaton Laboratories offers a variety of research and educational services for all phases of medicine. Our Medical Service Representatives at the Eaton Booth welcome the opportunity to furnish you with complete information covering these services to you and the nitrofurans.

Thomas A. Edison Industries
Voicewriter Division
Detroit, Mich. **No. 114**

Encyclopaedia Britannica
Chicago, Ill. **No. 106**

Encyclopaedia Britannica welcomes delegates to the Michigan State Medical Society Annual Session and invites them to examine the great new edition of Britannica.

Official delegates may now purchase this magnificent set at an offer only available at our convention exhibits. Visit Britannica's booth No. 106.

Fellows-Testagar
Detroit, Mich. **No. 107**

Fellows-Testagar features: Amodex Timed Capsules

(Anorexigenic); Pentryate Timed Capsules, (Vasoldilator) and Femogen Tablets (Conjugated Estrogens). Of special interest will be our new sampling technique — the RxAMPLE PROGRAM — the modern and convenient physician starter sample method.

Ferndale, Laboratories, Inc.
Ferndale, Mich. **No. 210**

FERNISONE-BUFF TABLETS — the 5mg prednisone with a "built-in-buffer:" Aluminum Hydroxide — Magnesium Carbonate Co-Dried gel 250 mg — a gastric antacid in dry form having extremely prompt and prolonged action in the optium pH range.

Please register and accept samples for evaluation.

Flint Laboratories, Inc.
Morton Grove, Ill. **No. 108**

Featured will be FLINT Laboratories' newly introduced CHOLOXIN® (sodium dextrothyroxine) which significantly lowers serum cholesterol physiologically, is significant in its ability to keep cholesterol levels down and convenient in its once-a-day dosage regimen. Also featured will be HU-TET® (tetanus immune globulin, human), the homologous tetanus antitoxin and SYNTHROID® (sodium levothyroxine) indicated in hypothyroidism.

Geigy Pharmaceutical
Ardsley, N. Y. **No. 704**

Geigy Pharmaceuticals cordially invites Members and Guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

Gerber Products Company
Fremont, Mich. **No. 310**

Please give us an opportunity to bring you up-to-date on recent developments in Gerber's *comprehensive* baby foods service. New editions of "Nutritive Values" and "Ingredients" of Gerber baby foods are available along with packets of individualized listings for the food-sensitive baby. We are here to serve you.

Hack Shoe Company
Detroit, Mich. **No. 206**

Among shoe firms, oldest and most consistent supporter of the medical profession, the Hack Shoe Company, will again display representative items from its stocks of regular, supportive and strictly prescription shoes.

The RIPPLE® sole shoe for surgeons and anesthesiologists will be highlighted.

Hoechst Pharmaceutical Company
Div. of American Hoechst Corp.
Cincinnati, Ohio **No. 404**

The representatives at Booth 404 will be happy to discuss Hoechst products with particular application to the physician's individual practice. Featured is Lasix® furosemide.

Key Pharmaceuticals, Inc.
Miami, Fla. **No. 117**

Key Pharmaceuticals, Inc., through its own research, developed a new and exclusive method of producing sustained-action tablets. By utilizing the developments of our research, Key has manufactured a number of products which produce sustained-action in treating chronic diseases.

We cordially invite you to visit our booth.

Lederle Laboratories
Pearl River, N. Y. **No. 410**

Lederle Laboratories is proud to support the 102nd Annual Session of the Michigan State Medical Society. As one of the leaders in medical research and quality controlled production, we present for your consideration products such as DECLOMYCIN®, ACHROMYCIN®V, ARISTOCORT®, LEVOPROME®, and others applicable to your practice. Our representatives in Booth No. 410 are also prepared to provide information on our numerous services to medicine.

Len-Tag Company
Detroit, Mich. **No. 701**

Len-Tag Company offers . . . . a complete group of *therapeutic agents* . . . . sixty formulations for *obesity con-*

trol . . . . a full line of *packaged medications* for the doctor whose practice does not allow him to use bulk medications.

Eli Lilly & Company
Indianapolis, Ind. **No. 616**

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance will welcome your questions about Lilly products. You may be particularly interested in discussing V-CILLIN K® Potassium Phenoxymethyl Penicillin.

J. B. Lippincott Company
Philadelphia, Pa. **No. 201**

Vital new Lippincott books on diagnosis and treatment on display are Bailey, RHEUMATIC AND CORONARY HEART DISEASE, Turek, ORTHOPEDICS, 2nd Edition, Moser and Goldman, HYPERTENSIVE VASCULAR DISEASE, McNeer and Pack, NEOPLASMS OF THE STOMACH, Collins, ILLUSTRATED MANUAL OF LABORATORY DIAGNOSIS, Houston, A SHORT TEXTBOOK OF MEDICINE, Taylor, A SHORT TEXTBOOK OF SURGERY, Osol, UNITED STATES DISPENSATORY AND PHYSICIANS' PHARMACOLOGY, Usdin, ADOLESCENCE and the new journal MEDICAL CARE.

Loma Linda Foods
Riverside, Calif. **No. 506**

Loma Linda Foods, one of America's oldest manufacturers of fiber-free soy milk, will explain why the product SOYALAC is unusual in that it does not settle out, is milklike in texture, and does not tend to raise infants' serum cholesterol. Samples of this flavorful, hypoallergenic milk will be served.

P. Lorillard Company
New York, N. Y. **No. 618**

You are cordially invited to visit the P. Lorillard Exhibit. We would like to give you a personalized gift package of KENT and TRUE, or if you are a menthol smoker, a personalized gift package of TRUE menthol cigarettes. As you enjoy these cigarettes, you will understand why we say — You can depend on Lorillard to be first with the finest cigarette through Lorillard research. Please stop by for your gift of KENT or TRUE cigarettes.

Marion Laboratories, Inc.
Kansas City, Mo. **No. 409**

PAVABID is a unique continuous release Plateau Capsule of papaverine hydrochloride providing vascular relaxant activity for 24 hours with a convenient b.i.d. dosage.

PAVABID may be utilized effectively for the relief of cerebral and peripheral ischemia associated with vascular spasms, arrhythmias, and myocardial ischemia complicated by arrhythmias.

Marshall Erdman & Associates, Inc.
Madison, Wis. **No. 702**

ERDMAN MEDICAL BUILDINGS

Marshall Erdman and Associates specialize in medical building planning and construction. More than 2000 doctors in 40 states practice in Erdman Buildings.

Erdman's experienced specialists will plan and build your building and assume total responsibility from the land planning stage through completion for occupancy. Their experience offers the busy physician the most efficient possible building at an economical guaranteed cost.

Marshall Erdman and Associates, Inc., Madison, Wisconsin, Princeton, New Jersey, Dallas, Texas.

Mead Johnson Laboratories
Evansville, Ind. **No. 510**

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medco Products Company
Detroit, Mich. **No. 613**

From the maker of the famous Medco Sonlator, the diagnostic as well as therapeutic device for muscle-skeletal problems, comes the new Achilleometer. The Achilleometer is a solid state computer for the determination of Achilles Reflex Test. The simplicity of operation permits immediate and accurate diagnosis.

Medical Protective Company
Fort Wayne, Ind. **No. 603**

With exceptional proficiency in defense, so essential to the doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim for damages based on professional services rendered or which should have been rendered. It's experience from the successful handling of 92,000 claims during 69 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Merck Sharp & Dohme
West Point, Pa. **No. 501**

The Merck Sharp & Dohme exhibit has been designed to supplement the physicians therapeutic armamentarium. Technically trained personnel are present to discuss the scope and variety of services offered.

Meyer Laboratories, Inc.
St. Clair Shores, Mich. **No. 110**

Each Athemol tablet contains 200 mg. Theobromine Magnesium Oleate. Each Athemol-N tablet contains 200 mg. Theobromine Magnesium Oleate and 100 mg. Magnesium Nicotinate.

Athemol and Athemol-N provide a well tolerated treatment for various forms of arteriosclerosis and peripheral vascular circulatory disease resulting from arteriosclerosis.

Michigan Association of Collection Agencies
Grand Rapids, Mich. **No. 607**

The Michigan Association of Collection Agencies and the 2,400 members of the American Collectors Association offer a realistic and productive approach to medical collection problems. We invite you to stop by the MACA booth with your questions and to learn who the member agencies are that serve your area.

Michigan Bell Telephone Company
Detroit, Mich. **Nos. 300-301**

Michigan Medical Service
Detroit, Mich. **No. 407**

You are cordially invited to visit the Michigan Medical Service exhibit (Booth 407) at the MSMS Annual Meeting in Grand Rapids. Members of our Professional Relations Staff will be there to welcome you and answer questions about Blue Shield, Medicare and Medicaid.

North American Pharmacal
Dearborn, Mich. **No. 614**

North American Pharmacal Co. will welcome members of the medical profession at the company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. North American recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you. Also available FREE CARICATURE DRAWINGS for physicians. We have a renowned artist at our booth to draw unique caricatures.

North States Aviation, Inc.
Grand Rapids, Mich. **No. 202**

Piper Aircraft Corporation, the World's leading producers of business and private aircraft, invites you to stop by their Learn to Fly Exhibit and pick up your complimentary copy of "Learn to Fly." You'll be amazed at just how easy it is to learn, and to get you started, a special introductory offer.

Ortho Pharmaceutical Corporation
Raritan, N. J. **Nos. 103 & 200**

Parke, Davis & Company
Detroit, Mich. **Nos. 400-401**

Medical service members of our staff are in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Pet Incorporated
St. Louis, Mo. **No. 707**

Our representatives will appreciate the opportunity to supply current information about two types of FORMIL infant formula — economical FORMIL concentrate for use with standard nursing bottles and convenient ready-to-feed FORMIL in completely disposable nursers (including disposable nipples). In addition, they will be glad to supply time-saving material for instructing mothers in the use of Pet Evaporated Milk formula.

R. J. Reynolds Tobacco Company
Winston-Salem, N. C. **No. 710**

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (Monogrammed with your initials) containing your choice of CAMEL, CAMEL Filter, WINSTON Filter, SALEM Filter, TEMPO Filter, or CAVALIER King Size Cigarettes.

A. H. Robins Company, Inc.
Richmond, Va. **No. 706**

You are cordially invited to visit the Robins display and meet our representatives who will welcome the opportunities to discuss products of interest with you.

Roche Laboratories
Nutley, N. J. **No. 309**

Continuing Roche research has produced outstanding contributions to medicine since 1909. The personnel at the exhibit welcome your comments, questions or suggestions about our products and services.

Rollins Shoes
Southfield, Mich. **No. 304**

TORQHEEL, an exciting new product providing you with a tool to effect dynamic in-plane rotation of the lower extremities is being featured at this meeting. TORQHEEL was designed to correct "toe-in" and "toe-out" problems in children, but has many applications in correcting foot alignment problems.

William H. Rorer, Inc.
Fort Washington, Pa. **No. 109**

William H. Rorer, Inc., takes great pride in exhibiting its fine pharmaceutical products at this convention. Our representatives will gladly discuss the merits of these products with you.

Ross Laboratories
Columbus, Ohio **No. 503**

Ross Laboratories presents three pediatric product lines plus current medical services.

1. SIMILAC® Infant Formula Products, featuring Similac ISOMIL™ and SIMILAC® 20 in Nursing Bottles.
2. PEDIAMYCIN™, cherry-flavored oral antibiotic effective against the common bacterial infections in children.
3. VI-DAYLIN® pediatric vitamins formulated in accordance with Recommended Dietary Allowances of the NRC.

Sandoz Pharmaceuticals
Hanover, N. J. **No. 115**

Sandoz Pharmaceuticals cordially invites you to visit our display at booth 115, where we are featuring Mellaril, Sansert, Cafergot P-B, Fiorinal and Fiorinal with codeine. Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company
Philadelphia, Pa. **No. 100**

Saunders will have on display a complete line of their medical books, including many new titles such as — Frieboes-Schonfeld: Dermatology; Conn: 1967 Current Therapy; Kendig: Respiratory Tract; Sodeman: Pathologic Physiology; Beeson and McDermott: Textbook of Medicine; Wells and Halsted: Clinical Pathology; Anderson: Boyd's Pathology for the Surgeon; and the A.C.S.: Manual of Preoperative and Postoperative Care.

Schering Corporation
Union, N. J. **No. 705**

Schering Corporation invites you to visit their exhibit, Booth Space No. 705 where their representatives will be available to discuss with you any questions you may have on ETRAFON®, AFRIN®, CELESTONE®, SOLUSPAN®, Injection, GARAMYCIN®, TINACTIN® or any other Schering product.

G. D. Searle & Company
Chicago, Ill. **No. 302**

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.
Featured will be Ovulen for ovulation control and menstrual disturbances, and Flagyl, a potent, new trichomonacidal agent for trichomonal vaginitis, cervicitis, urethritis and prostatitis.

Seven-Up Bottling Company of Western Michigan, Inc.
Holland, Mich. **Nos. 101-102**

Sherman Laboratories
Detroit, Mich. **No. 209**

Featuring
PERSISTIN® . . .

A unique salicylate with two significant therapeutic advantages: better gastric tolerance — reduces the chance of gastric irritation by 75%; and longer, more persistent analgesic salicylate serum levels. Relief from pain *all through the night* assures uninterrupted sleep, improvement of morale and absence of morning pain and stiffness in osteoarthritis patients.

Siemens Medical of America, Inc.
Addison, Ill. **No. 408**

SIEMENS MEDICAL will display many advancements in diagnostic and therapy equipment. Our representatives will be on hand to demonstrate our equipment and discuss practical applications with you. We believe a few minutes at our booth will prove to be well spent.

Smith Kline & French Laboratories
Philadelphia, Pa. **No. 500**

Representatives will be on hand to answer your specific questions and provide information on their products and services.

E. R. Squibb & Sons
New York, N. Y. **No. 600**

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

At booth 600, we will be pleased to present up-to-date information on these advances for your consideration.

Ben P. Stratton Agency, Inc.
Lansing, Mich. No. 507

Information concerning the group insurance plans sponsored by the Michigan State Medical Society is available. The Group Insurance Program consists of the following plans: (1) Long-term Disability, (2) Life Insurance, (3) Overhead Expense, and (4) High Level Accident. Descriptive literature may be obtained.

The Stuart Company Division,
Atlas Chemical Industries, Inc.
Pasadena, Calif. No. 403

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products, developed in our modern laboratories, which have particular interest for the medical profession. Products featured are MYLANTA, DIALOSE, DIALOSE PLUS, FERANCEE, MULVIDREN-F, MULVIDREN JUNIOR, MYLICON, STUART PRENATAL.

Syntex Laboratories, Inc.
Palo Alto, Calif. No. 606

SYNALAR® (fluocinolone acetonide), the topical corticosteroid designed to meet specific dermatologic needs, will be featured at Booth 606. SYNALAR has set a new standard of success in the treatment of a wide range of inflammatory dermatoses.
Also featured:

NORINYL® (norethindrone 2.0 mg with mestranol 0.1 mg) Tablets, an original steroid from SYNTEX LABORATORIES. NORINYL provides multiple contraceptive action that has produced a record of 100% effectiveness. Physicians may register at the SYNTEX exhibit for complete information on this outstanding product.

A warm invitation is extended to all physicians attending this meeting to visit our booth and discuss the latest developments from SYNTEX research.

S. J. Tutag & Company
Detroit, Mich. No. 700

S. J. TUTAG & COMPANY will feature its newest product—AQUATAG. Our representatives are looking forward to discussing the merits of AQUATAG as well as many other specialties in the Tutag line. Other products being featured at the Tutag booth: CYDRIL, ASMINOREL, GERITAG, QUADAMINE and NEOTEP.

Union Bank & Trust Company
Grand Rapids, Mich. No. 612

"Medac," an abbreviation of medical accounting, will be demonstrated by Union Bank, using an actual unit connected by phone line to the bank's computers. Tried and tested nationwide, this complete billing and disbursement service for physicians is available in Western Michigan only at Union Bank.

United States Tobacco Company
New York, N. Y. No. 406

United States Tobacco Company will display its KING SANO, KING SANO MENTHOL Filter tip Cigaraettes, SANO BELVEDERE Cigars, SANO Pipe Tobacco and LITTLE SANO Cigars . . . all with less than 1% nicotine by tobacco weight. SANO products meet the nicotine problem in the only effective way by reducing the nicotine in the tobacco leaf itself before SANO tobacco products are manufactured. SANO cigarettes, cigars, and pipe tobacco for good sense and good taste.

U. S. Vitamin & Pharmaceutical Corporation
New York, N. Y. No. 118

The USV Pharmaceutical Corporation cordially invites you to visit their exhibit where DBI-TD and ARLIDIN will be on display. Professional sales representatives will be in attendance to welcome you and to answer any inquiries.

Warren-Teed Products Company
Columbus, Ohio No. 509

Wallace Laboratories
Cranburg, N. J. No. 505

We invite you to visit our booth where our representatives in attendance will be pleased to furnish information regarding Wallace products and your related medical questions to assist you in your practice.

Westwood Pharmaceuticals
Buffalo, N. Y. No. 502

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:

Fostex Cream
Fostex Cake
Sebulex
Fostril
Alpha-Keri
Keri Lotion

These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

Winthrop Laboratories, Inc.
New York, N. Y. No. 116

Winthrop Laboratories cordially invites you to visit Booth 116 where the following products will be featured:

pHisoHex®, antibacterial skin cleanser containing 3 percent hexachlorophene, of proven efficiency.
NegGram® (brand of nalidixic acid).
Isuprel (brand of isoproterenol) Mistometer.®

WTS-Pharmacraft
Rochester, N. Y. No. 617

DESENEX: Most widely prescribed fungicide used in the prevention and treatment of athlete's foot and other superficial fungus infections of the skin.

CALDESENE: Provides a lubricating and emollient film which is effective in the prevention or treatment of diaper rash and minor skin irritations.

CRUEX: Spray-on Powder (new) for Jock Itch.

Wyeth Laboratories
Philadelphia, Pa. No. 402

Wyeth will feature . . .

PHENERGAN® EXPECTORANT
The basic formula for all PHENERGAN® Expectorants: Each 5-cc. teaspoonful contains promethazine hydrochloride, 5 mg.; fluidextract ipecac, 0.17 min.; potassium guaiacolsulfonate, 44 mg.; chloroform, 0.25 min.; citric acid, anhydrous, 60 mg.; sodium citrate, 197 mg.; in a pleasantly flavored syrup base; alcohol 7%.

In addition to the basic formula — VC Expectorants contain phenylephrine hydrochloride, 5 mg.; Expectorants with Codeine contain codeine phosphate, 10 mg. (1/6 gr.) Warning — May be habit forming.

Pediatric Expectorants contain dextromethorphan hydrobromide, 7.5 mg.

OMNIPEN® (ampicillin) Wyeth
Full information is available at booth 402.

Wynn Pharmaceuticals, Inc.
Philadelphia, Pa. No. 508

QUINAGLUTE® DURA-TABS®: Quinidine gluconate tablets for maintenance of normal sinus rhythm with convenient, well-tolerated q. 8 h. or q. 12 h. dosage.

AMINOPHYLLINE DURA-TABS®: 4-½ grains, prolonged-action, well tolerated.

NUMA® DURA-TABS®: An improved, prolonged-action formula for the relief of chronic bronchial asthma.

HISTADUR® DURA-TABS®: Chlorpheniramine maleate in a prolonged-action formula for relief of hay fever and other allergic disorders.

MSMS SCIENTIFIC EXHIBIT DESCRIPTIONS

Space 1-A

"Epiphyseal Injuries"

A. Jackson Day, MD — Orthopedic Department, Childrens Hospital, Detroit.

X-Ray exhibit of actual cases of epiphyseal injury, and the effects of growth upon such injuries.

Space 1-B

"Improving the End Bearing Characteristics of Lower Extremity Amputation Stumps by the Use of Silicone Rubber Implants"

Alfred B. Swanson, MD, Brian L. Hotchkiss, MD, Charles H. Frantz, MD — Blodgett Memorial Hospital Department of Medical Research, Grand Rapids

The many advantages of a Symes-type of knee disarticulation-type amputation are well known in the medical and prosthetic professions. In order to produce similar end-bearing characteristics at more proximal below-knee and above-knee levels, a Silicone rubber surgical implant has been developed. Its use has been complemented by the adaptation of modern prosthetic principals.

Space 2-A

"Chronic Dialysis Program"

Mt. Mary's Hospital — Grand Rapids

Space 6-A

"A New Method of Measuring Myocardial Blood Flow in Man"

Richard J. Bing, MD, Clark Daniels, MD, Albert Cohen, MD, Edward Zaleski, MD, Charles Cowan, MD — Wayne State University, Detroit

This exhibit explains a new method measuring myocardial coronary blood flow and its clinical application. The aspects to be stressed are the principle of coincidence counting with the procedures as carried out on more than 1,000 patients using a steady (infusion) state or a single injection method. The diagnostic values of recognizing coronary artery disease by this method will be explained through the use of text, charts, graphs, and illustrations.

Space 6-B

"Insure Femaleness-Control Conception"

F. P. Rhoades, MD — Detroit

Woman at any age may be deficient in the amount of estrogens needed to insure true femaleness. This is determined from a history, a physical examination, and cytograms. Continuous estrogen therapy for 28 days with progesterone added the last 7 days produces a 28 day cycle that simulates normal menstruation. A compilation of twenty common symptoms with the percentage of relief obtained following therapy is depicted. The exhibit is based on clinical investigation in private practice of a new estrogen-progesterone combination (under F.D.A. rules).

Space 8-A

"Alcoholism Is Your Business"

MSMS Committee on Alcoholism and Drug Addiction and American Medical Association.

Alcoholism is the doctor's business. This exhibit, aimed at physicians, points out that alcoholism is a disease and can be treated by a physician.

Subjects covered are early recognition, laboratory procedures, history, physical examination, and methods of treatment. The center part of the exhibit is a recorded telephone conversation between a distraught wife of an alcoholic and a physician. The psychological and social changes encountered in the alcoholic are depicted.

Space 8-B

"Dose Response: Key to Effective Treatment"

Fred J. Phillips, MD, David M. Shoemaker, MD, C. L. Chai, MD, M. D. Debugue, MD — Quakertown, Pa.

This exhibit is designed to show how titration of dose may be carried out after maximum therapeutic response has been reached, thus reducing the cost of medication to the patient. Reduced drug exposure may also aid in reduced toxicity and side effects for the patient.

Space 8-C

"Clinical Application of Physical Therapy Modalities"

Frank S. Blumenthal, MD — Michigan Academy of Physical Medicine and Rehabilitation

Clinical application of various physical therapy modalities is presented by means of an automatic slide program, and by illustrative material. Emphasis is on the practical aspects of dosage, indications, physiologic effects, techniques of use, and equipment characteristics for such modalities as diathermy, ultrasound, topical heat, intermittent pressure, and therapeutic exercise.

Space 8-D

"Management of the Multiple Sclerosis Patient"

George J. Boines, MD, Wilmington, Del.

Charts, graphs, diagrams and case histories delineate the medical management of the multiple sclerosis patient. Intrathecally injected methylprednisolone, as one aspect of the medical rehabilitation schedule, appears beneficial to these patients, probably through its local anti-inflammatory activity. The method of management and the results in over 300 MS patients are demonstrated.

Space 8-E

"Surgery of the Arthritis Foot"

American Academy of Orthopaedic Surgeons and Michigan Chapter, Arthritis Foundation

This News Extra Contains Your Annual Session Preliminary Program Grand Rapids, Sept. 27-28-29

DINNER DANCE

The 1967 Annual MSMS State Society Dinner Dance, Wednesday, September 27, will take on a "Celebrity Night" atmosphere.

All MSMS members are invited to help focus attention on the honored guests and special celebrities.

THE DINNER DANCE will be the social highlight of the MSMS Week-in-Grand Rapids. There will be excellent food, warm fellowship, enjoyable dance, music, and special spotlight festivities.

B. M. Harris, M.D., Ypsilanti, will be installed as the 102nd MSMS President, succeeding C. Allen Payne, M.D., Grand Rapids.

The MSMS members who are serving as presidents of national medical organizations will be presented MSMS awards as part of the program.

Presidents of the MSMS component medical societies also will be in the spotlight in recognition of the important roles they play.

The presidents of the State Woman's Auxiliary and the State Medical Assistants Society will step into the spotlight too.

THE PLANNING COMMITTEE for the gala Dinner Dance points out that the event again will be black tie—optional with the ladies in their prettiest evening gowns.

Interested MSMS members are urged to use the reservation blank to assure themselves of a share in the celebrity night.

MAIL TO MSMS, P.O. BOX 152, EAST LANSING

RESERVATION ORDER
MSMS DINNER DANCE, SEPT. 27

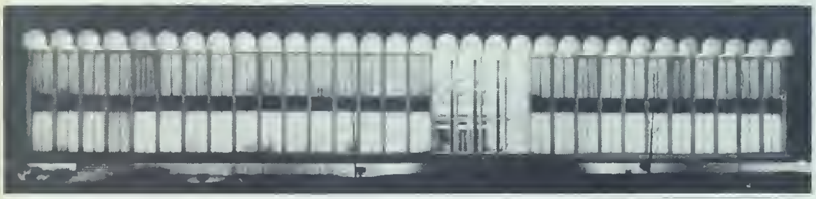
Please reserve ____ tickets for the Annual MSMS Dinner Dance at 7 p.m., September 27 at the Civic Auditorium. Attached is my check for tickets, $10.00 per person.

Name ______________________________

Address ______________________________

City ______________________________

Second Class Postage Paid at Lansing, Mich.



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MICHIGAN STATE MEDICAL SOCIETY

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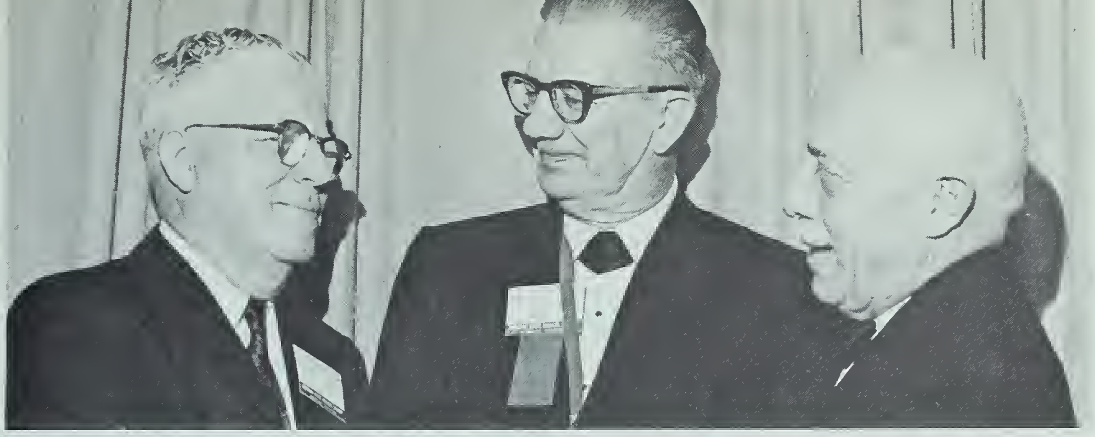

OUTGOING PRESIDENT PAYNE, CENTER, AND INCOMING PRESIDENT HARRIS, RIGHT, CONGRATULATE PRESIDENT-ELECT LIGHTBODY

Harris Installed; House Elects Blodgett as Speaker, Lightbody As Next President; Mason Renamed

U.C. MEDICAL CENTER LIBRARY
NOV
San Francisco 22

The leadership of MSMS today lines up with:

President: B. M. Harris, M.D., Ypsilanti
President-Elect: James J. Lightbody, M.D., Detroit
Speaker: James B. Blodgett, M.D., Detroit
Vice-Speaker: Vernon V. Bass, M.D., Saginaw
Council Chairman: Robert J. Mason, M.D., Birmingham
Council Vice-Chairman: Ross V. Taylor, M.D., Jackson

These men were installed or elected at the 1967 Annual Session in Grand Rapids, along with others who were elected to The Council, to the AMA House of Delegates, and to other responsible positions.

THE MSMS HOUSE of Delegates, at its closing session, unanimously elected Doctor Lightbody as the President-Elect. He had served for eight years as Speaker of the House of Delegates.

The Delegates selected, also unanimously, Doctor Blodgett as the new Speaker and Doctor Bass as the new Vice-Speaker. Louis F. Hayes, M.D., Gaylord, who had served as Vice-Speaker, was not a candidate after announcing the day before that he had accepted a new position with Michigan Medical Service.

THE DELEGATES returned seven councilors to the MSMS Council for new terms. They were: Ralph R. Cooper, M.D., Don W. McLean, M.D., and Robert K. Whiteley, M.D., all of the 1st District; Don Marshall, M.D., Kalamazoo, 4th District; John R. Pedden, M.D., Grand Rapids, 5th District; Harold H. Hiscock, M.D., Flint, 6th District, and Harold F. Falls, M.D., Ann Arbor, 14th District.

Re-elected as Delegates to the AMA to 1969 were Otto K. Engelke, M.D., Ann Arbor; John R. Heidenreich, M.D., Daggett; Luther R. Leader, M.D., Royal Oak, and Robert E. Rice, M.D., Greenville.

Elected for the first time as Alternate Delegates to the AMA were Paul T. Lahti, M.D., Royal Oak, and John W. Moses, M.D., Detroit. Reelected were Harold A. Furlong, M.D., Pontiac, and B. M. Harris, M.D., Ypsilanti.

WHEN THE COUNCIL reorganized on September 28, Doctor Mason and Doctor Taylor were re-elected as Chairman and Vice-Chairman, respectively. Chosen as chairmen of The Council Standing Committees were Doctor Whiteley, Finance, and Brooker L. Masters, M.D., Fremont, Publication, both re-elected; and John J. Coury, M.D., Port Huron, County Societies Committee.

See Proceedings for Official Wording:

Delegates Act on Blue Shield, Abortion, Osteopaths, Many, Many Other Subjects

Action was taken by the 1967 MSMS House of Delegates on many issues that effect the general public. Action was taken, too, that has a direct bearing on the physician, his county medical society and the state society in such fields as socio-economics, postgraduate education, political influence and others.

The complete, Official Proceedings of the House of Delegates again will be printed in a special issue of *Michigan Medicine* in December. MSMS officials now are awaiting the official transcript.

AN UNOFFICIAL REPORT was mailed the day after the House adjourned to the delegates and alternates, to county medical society presidents, secretaries, executive secretaries and bulletin editors, and also to all members of the MSMS Council. The mimeographed report was designed to assist the delegates in making their reports back to their county medical societies.

The news media carried considerable copy about several of the actions of the House which concerned the health care of the public. These stories dealt with the House action (1) to open the MSMS doors to osteopaths as Associate members on an individual basis, (2) to work for the liberalization of state abortion laws, and (3) to continue efforts to relieve medical manpower shortages.

BLUE SHIELD officials caught the attention of the news media with the report that Blue Shield has asked the State Insurance Commissioner for approval to offer to expand medical care contract with physicians to be paid according to a new "variable fee" concept.

Accepts D.O. as Associate

The delegates approved a resolution which encourages the coun-
ty medical societies to offer ass
ciate memberships to local oste
pathic physicians on an individu
basis.

The delegates also approve
Richard Remsberg, D.O., Alma,
the first associate member
MSMS in its 102 years of histor
Doctor Remsberg has been an a
sociate member for the past ye
of the Gratiot-Isabella-Clare Med
cal Society, which recommende
him for state affiliation.

The resolution, adopted by th
MSMS delegates, reported th
"many osteopathic physicians hav
benefitted from their associatio
with medical doctors and have e
pressed a desire to develop a clo
er professional relationship wit
medical societies."

Doctor Remsberg, who has pra
ticed more than 10 years at Alm
is a member of the joint staff a
the Gratiot Community Hospita
at Alma. The state society has en
couraged joint hospital staffs, an
each year more hospitals have ad
mitted selected osteopaths to pra
tice.

Resolutions Bear on MMS

There were a number of resolu
tions which dealt with various as
pects of Michigan Medical Service
Several were approved by the dele
gates. Four are described briefl
below:

The House recommended to th
Board of Directors of Michigar
Medical Service that the right o
individual case participation b
included without restriction in al
new contracts (Resolution No
32).

The House urged the Board o
Directors of Michigan Medica
Service to establish an improve

SPEAKER JAMES B. BLODGETT, M.D.

VICE SPEAKER V. V. BASS, M.D.

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eview of 1967
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echanism to promptly resolve uestions from physicians concern-g "Medicare" and "Medicaid" ses (Resolution No. 33).

he House directed that MSMS tablish an appropriate appeal echanism, available to either ichigan Medical Service or to e physician concerned, to cover e problems unresolved at the unty level (Resolution No. 59).

he House suggested that Michi-an Medical Service require spe-ific instruction from the attend-g physician as to type, amount nd duration of physical and/or ccupational therapy found neces-ry for Title 19 patients, and re-uested that the physician be re-nbursed for examination, pre-cription and supervision of the herapy (Resolution No. 20, as mended).

Among Other Actions:

This article makes no attempt describe all the actions of the ouse of Delegates on resolutions. nd committee reports. Interested hysicians should read the Official roceedings in the December issue f *Michigan Medicine*. The fol-owing information is excerpted rom the unofficial summary that was mailed to delegates and coun-y societies. Again, the Official Proceedings will carry the com-lete, exact language.

The House directed the President of MSMS to appoint a fact-inding committee "to evaluate the tilization of prepaid medical services in Michigan." In so doing the House did not approve the Hospital Utilization Review Manual as it now exists, but recommended that the Coumittee on Evaluation of Prepaid Medical Services explore with hospital medical staffs the effectiveness of the manual's guidelines (Amendment to report of the Reference Committee on Reports of Committees, p. 2).

The House reaffirmed its support for a strong, separate State Department of Public Health and its opposition to any combination of this department with another state agency (Resolution No. 49).

The House directed the Legal Affairs Committee to study the feasibility of a law to require that all ethical licensed physicians have staff privileges in at least one accredited, full-facility community hospital, and to report to the House of Delegates in 1968 (Resolution No. 56).

The House directed that MSMS work toward revision and liberalization of the current Michigan abortion statutes (Resolution No. 40).

THE HOUSE AUTHORIZED inclusion of MDPAC dues in the MSMS dues billing with a footnote stating clearly that this (MDPAC) portion is voluntary and not deductable (Resolution No. 41).

The House directed that MSMS cooperate with the three Michigan Medical Schools and their Student Medical Association chapters to establish a "preceptorship program" throughout the State (Substitute Resolution No. 46).

The House amended the Bylaws membership provisions to specifically provide that "there shall be no discrimination on the basis of race, religion, sex or ethnic origin." (Supplemental report, Reference Committee on Constitution and Bylaws).

THE HOUSE STATED that where governmental agencies still require payment to be made in accordance with a fee schedule, the 1967 RVS is to be used. (Reference Committee on Health Insurance and Medical Service, p. 5).

The House urged all county medical societies which have not yet participated in the Measle Immunization Program of the MSMS Committee on Public Health to do so (Reference Committee on Reports of Committees, p. 6).

STORIES ABOUT House action will appear in many future issues of *Michigan Medicine.*

HENRY COOK, M.D., FLINT, RECEIVED THE "OUTSTANDING PHYSICIAN OF THE YEAR AWARD" FROM MSMS PRESIDENT C. ALLEN PAYNE, M.D., BEFORE THE HOUSE OF DELEGATES FOR HIS DISTINGUISHED MEDICAL CAREER, DEDICATED SERVICE TO CHILDREN AND YOUTH IN FLINT, AND LONG YEARS OF SERVICE TO MSMS. (SEE OCTOBER ISSUE OF MICHIGAN MEDICINE FOR DETAILS.)

MRS. W. G. GAMBLE, JR.

MRS. GAMBLE LEADS AUXILIARY; ELECT MANY OFFICERS

Installed as president of the Woman's Auxiliary to MSMS during ceremonies during their annual meeting in Grand Rapids in September was Mrs. W. G. Gamble, Jr., of Bay City.

Mrs. Earl E. Weston, Birmingham, was chosen president-elect for 1967-1968 during the September 27 elections. She will become president in September 1968. Mrs. Weston was first vice president during the past year.

Replacing Mrs. Weston as first vice president is Mrs. Edward S. Maxim, St. Clair Shores, and second vice president is Mrs. Francis P. Rhoades, Detroit.

Three secretaries were chosen: Mrs. Fred M. Maynard, Allen Park, is the new recording secretary; Mrs. G. L. Hagelshaw, Bay City, corresponding secretary; and Mrs. Howard R. Williams, Ann Arbor, financial secretary.

Reelected treasurer was Mrs. Otto Engelke, Ann Arbor. Also reelected were Mrs. Roy Matthews, Jr., Charlotte, members-at-large coordinator; Mrs. Clarence Crook, Ann Arbor, parliamentarian; and Mrs. F. Mansel Dunn, East Lansing, *Auxilium* editor. Mrs. Henry P. Kooistra, Grand Rapids, was chosen as the new historian.

New district directors elected for two-year terms are Mrs. Arnold A. Albright, Battle Creek, District III, and Mrs. Donald N. Fitch, Bayview, District IX. Continuing as directors are: Mrs. Robert K. Hart, Croswell, District I; Mrs. C. J. Stringer, East Lansing, District II; Mrs. Robert E. Bloom, North Muskegon, District IV; Mrs. Ralph Dawson, Flint, District V; Mrs. Philip K. Wiley, Traverse City, District VII; and Mrs. Maurice D. Meier, Calumet, District VIII.

Don't Toss It Out

Yes, these light blue pages in the middle of every month are part of *Michigan Medicine* and should be saved by medical librarians and others as part of the 1967 bound volume. The mid-month *News Extra* pages are numbered consecutively with the regular journals that appear early each month.

Some librarians have discarded the blue *News Extra* only to find that later they must write for an extra copy for the bound volume.

The *Michigan Medicine News Extra* is mailed to all members around the 15th day of each month. Deadline for the December issue is December 15. Send news and photographs to: Herbert A. Auer, Managing Editor, *Michigan Medicine,* Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.

Four Doctors Begin MMS Board Terms

Seven new men were elected to the Michigan Medical Service Board of Directors during the corporation's annual meeting September 26 in Grand Rapids.

Four of the new members are physicians. They are: Roy J. Gerard, M.D., of Saginaw; Robert H. Hamburg, M.D., of Detroit; Arthur V. Levant, M.D., of Detroit; and George L. Reno, M.D., of Detroit.

Other new members are Earl E. Conlin, vice president, Ex-Cello-O Corp., Detroit; John R. Cooke, industrial relations director, the Bendix Corp., Detroit; and John Feikens, Detroit attorney.

Five physicians were re-elected to the board: William R. Gladstone, Jr., M.D., of Norway, Mich.; Benjamin Jeffries, M.D., of Detroit; Richard McMurray, M.D., of Flint; Julien Priver, M.D., of Detroit; and Robert Stow, M.D., of Lansing.

Other men re-elected to the board are: Howard N. Maynard, president, Snyder Corp., Detroit; Carl H. Morgenstern, chairman of the board, Old Kent Bank and Trust Company, Grand Rapids; Alfred M. Pelham, assistant vice president for finance, Wayne State University, Detroit; and Kenneth E. Wolz, administrator, Saginaw General Hospital, Saginaw.

Clinic Day Nov. 2 At Battle Creek

Calhoun, Branch, and Eaton county medical societies will present their annual Southwestern Michigan Clinic Day, November 2 at the Battle Creek Country Club.

The full day of scientific talks and discussions will be opened at 9:30 a.m. by Robert L. Lamb, M.D., Battle Creek, who will speak on "Special Problems of Childhood and Adolescence." Climax of the day will be the Third Annual Russell L. Mustard Lecture to be delivered by Charles F. Gregory, M.D., professor and chairman of the Division of Orthodepics, Department of Surgery, University of Texas Southwestern Medical School at Dallas. Doctor Gregory will speak on "Fat Embolism."

Other speakers will be: Irving Bush, M.D., chairman of the Department of Urology, Cook County Hospital, Chicago, on "Genital-Urinary Tract Trauma;" Peter Forsham, M.D., professor of medicine and pediatrics, University of California Medical Center, on "Modern Concepts of Diabetes and Its Management;" Charles Rob, M.D., chairman and professor of surgery at the University of Rochester School of Medicine and Dentistry, on "Coeliac and Mesenteric Artery Disease;" Orliss Wildermuth, M.D., director, Tumor Institute of the Swedish Hospital, Seattle, on "Should He Have Radiation Therapy for His Cancer?" and Sture Johnson, M.D., chairman of the Department of Dermatology, University of Wisconsin Medical Center, on "Something New and Different in the Treatment of Common Skin Problems."

For reservations and further information contact: J. Alan Gray, M.D., 309 Michigan National Bank, Battle Creek, Mich. 49014. Tel: (616) 965-5191.

Many, more photos and articles about the 1967 House of Delegates, Annual Session and related activities will appear in the November issue of Michigan Medicine.

RICE APPOINTED ACTING DIRECTOR OF STATE HEALTH

Acting director of the State Department of Public Health is R. Gerald Rice, M.D., Lansing.

Doctor Rice was appointed to the position following the resignation of Albert E. Heustis, M.D. Doctor Heustis is now the director of the Michigan Association of Regional Medical Programs, Inc.

Governor Romney will appoint Doctor Heustis' successor with the approval of the Legislature.

Doctor Rice joined the Michigan Department on January 2, 1964 and is Associate Director for Maternal and Child Health (which includes the Crippled Children's Commission) and Chief of the Bureau of Maternal and Child Health.

Rheumatic Fever Conference, Nov. 8

Interested MSMS members are invited to participate in a Rheumatic Fever Conference, from 11:30 a.m. to 5:00 p.m., Wednesday, November 8, at the Kellogg Center, M.S.U., East Lansing. Advance registration is necessary; write to Kellogg Center.

Speakers at the conference, designed to present current clinical concepts of RF and review RF control and ways in which its programs can be strengthened, include: Alvan R. Feinstein, M.D., Associate Professor of Medicine and Epidemiology, Yale University; "RF and RF Heart Disease Control;" Kurt Biss, M.D., DeKalb, Ill.; "The Illinois RF Emphasis Program;" Sandra Daugherty, M.D., chief, H.D. Control Section, Michigan Department of Public Health; "Public Health's Role in RF;" Jessie V. Pergrin, R.N., director, Wayne County Division of Public Health Nursing; "The Public Health Nurse's Role in RF;" and Tom B. Thompson, M.D., Jackson, "Office Throat Cultures."

BOTH THE INCOMING MSMAS PRESIDENT, MRS. NELDA GASPERSON, RIGHT, AND THE RETIRING PRESIDENT, MRS, ALTA GREEN, ARE IN THIS HAPPY PHOTO AS CARL KING, JR., PRESENTS THE ANNUAL MEDICAL, DENTAL, HOSPITAL BUREAU "MEDICAL ASSISTANT OF THE YEAR AWARD" TO MRS. GASPERSON.

WSU Plaque Ceremonies Nov. 3 to Recall Beginning of Detroit Medical College

A plaque to mark the beginning of the medical school in 1868 will be unveiled at Martin Place and Woodward Avenue in Detroit on Nov. 3 as the first major event of the Wayne State University Centennial.

James M. Hare, Michigan Secretary of State, will speak at the ceremonial event at the site of the original medical school. The charter for the Detroit Medical College, the forerunner of WSU, was issued on June 13, 1868.

Harris Brings to Presidency Experience in Many Fields

Bradley M. Harris, M.D., Ypsilanti, was installed as the 102nd president of the Michigan State Medical Society during ceremonies September 27 in the Grand Rapids Civic Auditorium.

Doctor Harris succeeds C. Allen Payne, M.D., Grand Rapids.

Prominent in civic and professional affairs, Doctor Harris is immediate past president of the Ypsilanti Chamber of Commerce. He is a past president of the Washtenaw County Medical Society and has been a member of the MSMS Council for 17 years.

Doctor Harris was chairman for many years of the MSMS Publication Committee, which is responsible for the publication of *Michigan Medicine.*

He has devoted much effort to the Michigan United Fund, serving as vice president, member of the Board, and chairman of the Medical Advisory Committee.

Other memberships and offices include: the American Medical Association, American College of Surgeons, Detroit Academy of Surgery, Michigan State Board of Registration in Medicine, Washtenaw County Medical Society Executive Council, Washtenaw County Red Cross Blood Bank Committee, American Legion, and Ypsilanti Historical Society.

Doctor Harris, born in Sebewaing, was graduated from Michigan State Normal College (now Eastern Michigan University) in 1927 with an A.B. degree. He received his M.D. degree from the University of Michigan Medical School in 1931. He is affiliated with Beyer Memorial Hospital in Ypsilanti and St. Joseph's Mercy Hospital in Ann Arbor.

The bells in WSU's Mackenzie Hall rang 10 times on the opening day of the 1967-68 schoo year as more than 31,000 students began classes i the University's 100th year.

WSU's Centennial Year, which will be observe with a program of activities extending throug June, commemorates the beginning of the first o the University's 10 schools and colleges.

A dinner in tribute to WSU is being prepare by 100 leading Detroit citizens for the evening o June 13 in Cobo Hall. Mayor Jerome P. Cavanagh and Governor George Romney are honorar co-chairmen of the tribute dinner. Walker L. Cisler, chairman of the board of Detroit Edison Co. is general chairman.

The theme of Wayne's Centennial Year is "Th Urban University and Urban Society." Program for the year are part of a major examination o the role of the urban university in the troubled American city.

Problems of the urban world will be examined in a series of seven Centennial Symposia on such problems as racial tension, health, city planning, technology and education and culture.

MRS. GASPERSON TO LEAD ASSISTANTS

The officers of the Michigan State Medical Assistants Society for the year 1967-1968 are:

President, Mrs. Nelda Gasperson, Mt. Clemens.

President-Elect, Mrs. Mary Jordan, Eaton Rapids.

Vice-President, Mrs. Patricia Austin, Ann Arbor.

Recording Secretary, Mrs. Betty Boers, Kalamazoo.

Treasurer, Mrs. Donna Fogal, Port Huron.

Speaker-of-the-House of Delegates, Mrs. Dorothy Brandis, Lansing.

The Medical Assistant of the Year is Mrs. Nelda Gasperson. There were 13 candidates for this honor which was announced at the 1967 convention.

Attendance was good with over 200 registered in Grand Rapids.

100 Billboards Help in Recruiting

People all over Michigan are seeing billboards reading "Over 200 Medical Careers. One May Be Just Right for You."

The striking, seven-color posters were for the first time made available at cost by the American Medical Association, and the Michigan Outdoor Advertising Council and its affiliated members are posting 100 of the boards as a public service.

The billboards urging people to enter health careers coincides with Community Health Week, October 15-21. Since the billboards are strategically located to catch the public's eye, the message will reach a large segment of the Michigan populace.

The new "Project Billboard" is sponsored by the MSMS Public Relations Committee and the Michigan Health Council as part of their continuing efforts at health career recruitment.

MDHP CONCLAVE SOON ON EPIDEMIOLOGY

The Third Conference on Epidemiology sponsored by the Bureau of Community Health of the Michigan Department of Public Health will be presented December 13, 14 and 15 at the Inn America, East Lansing.

The program tentatively includes sessions on: Tuberculosis and Chemoprophylactic Treatment; Hepatitis and Shigella as Related to Institutional Control Measures; Venereal Disease Control Screening Methods; and Cancer Epidemiology.

Tuescher Directs United Health Fund

New executive director of the United Health Fund in Detroit is Edward W. Tuescher. Previous to his appointment, Mr. Tuescher was executive vice-president of the Michigan Cancer Foundation, with whom he worked for seventeen years.

"We hope to be the instrument for bringing about some joint planning and dialogue between official and voluntary health agencies in this area," he said in commenting on the objectives of the United Health Fund.

T OUT AND RETURN THIS BLANK
R VALUABLE MATERIALS . . .

The following materials may be useful to you. Check any item ded, cut out the form, and mail it in an envelope to: Michigan State dical Society, 120 West Saginaw, East Lansing, Michigan 48823.

_The American Medical Association — pamphlet describing the history, organization, work, goals, etc. of the AMA.

_Drugs Anonymous? — Pharmaceutical Manufacturers Association booklet on prescribing medicines by generic name.

_Immunization — Discussion of various immunizations, when they should be administered, etc. Published by the AMA.

_Rx Chronic Bronchitis, Emphysema, Bronchial Asthma, Tuberculosis — An outline of treatment prepared for physicians and published by the Michigan Tuberculosis and Respiratory Disease Association.

_What Makes Sammy Smoke? — Brochure by the Michigan Cancer Foundation attempting to point out why children begin to smoke and what parents can do to prevent it.

WSU Centennial Symposium to Look At City Environment

One of the 11 symposia offered by Wayne State University during its Centennial anniversary which will be of high interest to physicians is "The City as Environment: Biological and Social Implications," to be held November 16 and 17 at the McGregor Memorial Conference Center.

Among the distinguished speakers at this symposium are: Leonard J. Duhl, M.D., Special Assistant to the Secretary, Department of Housing and Urban Development; Richard A. Prindle, M.D., Assistant Surgeon General, and Bureau Director, Bureau of Disease Prevention and Environmental Control, Department of Health, Education, and Welfare; Philip R. Lee, M.D., Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare; and John Hanlon, M.D., Health Commissioner, City of Detroit.

A detailed program may be obtained from: The Centennial Symposia, 5229 Cass Avenue, Detroit 48202.

Offer WSU Symposium On Pre-Natal Life

"Biological and Clinical Perspectives of Pre-Natal Life" is the theme of a two-day symposium on the physiology and pathology of reproduction to be held November 1-2 in the Rackham Educational Memorial Building, Detroit.

Sponsored by the Department of Gynecology and Obstetrics of the Wayne State University School of Medicine and the Department of Obstetrics and Gynecology, Harper Hospital, the symposium will mark 100 years of cooperation between the two institutions.

For information please write to Harold Mack, M.D., professor of gynecology and obstetrics, WSU School of Medicine, 1400 Chrysler Freeway, Detroit, Michigan 48207.

FOUR PG COURSES IN NOVEMBER

The final four in the fall MSMS series of postgraduate lectures and clinical programs will be held in November. Fourteen are being held in October.

The series, arranged by the MSMS Committee on Postgraduate Medical Education, will close with:

GRAND HAVEN, NOV. 3

Afternoon Clinic: Thomas A. Bruce, M.D., WSU; Stewart E. Pursel, M.D., WSU.

Dinner Meeting: Doctor Bruce on "Medical Aspects of Cardiac Surgery," and Doctor Pursel on "Surgical Aspects of Cardiac Surgery."

PETOSKEY, NOV. 9

Afternoon Clinic

Dinner Meeting: William R. Olsen, M.D., U-M, on "Shock," and Neal A. Vanselow, M.D., U-M, on "Advances in the Field of Allergy."

TRAVERSE CITY, NOV. 14

Dinner meeting: John A. Penner, M.D., U-M, on "Hemorrhage and Thrombosis."

MIDLAND, NOV. 16

Afternoon Clinic: Reed O. Dingman, M.D., U-M; F. Bruce Fralick, M.D., U-M; E. Richard Harrell, M.D., U-M; Reed M. Nesbit, M.D., U-M; Harry A. Towsley, M.D., U-M; Walter P. Work, M.D., U-M.

Dinner Meeting

Nine Michigan Men Cited as Nat'l Presidents

One of the highlights of the 1967 State Society Dinner Dance at the Annual Session was the presentation of awards to Michigan physicians who are presidents of national medical organizations.

The awards were given by the MSMS President to the following:

George H. Agate, M.D., Lansing — Conference of State and Territorial Epidemiologists
Luther C. Carpenter, M.D., Grand Rapids — Commission on Professional and Hospital Activities
A. James French, M.D., Ann Arbor — International Academy of Pathology
William N. Hubbard, Jr., M.D., Ann Arbor — Association of American Medical Colleges
Clarence S. Livingood, M.D., Detroit — American Academy of Dermatology
Norman N. Nigro, M.D., Detroit — American Proctologic Society
Ross V. Taylor, M.D., Jackson—American Therapeutic Society
Raymond W. Waggoner, M.D., Ann Arbor—American College of Psychiatrists and American Association of Professors of Psychiatry

One other honoree was not able to be present:

Lionel F. Swan, M.D., Detroit—National Medical Association

MSMS has presented its "National President's Award" for a number of years but had not awarded any since the 1966 County Officers Conference. In several cases the physicians had completed their term of office.

Many other Michigan physicians are serving now as presidents-elect, secretaries, executive officers and as board members of many national medical and health organizations.

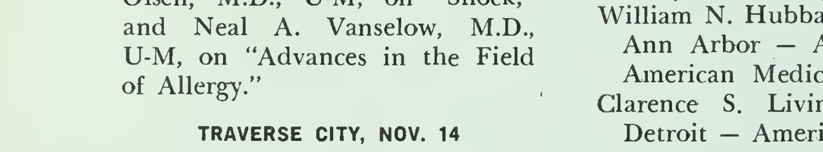
MEDICAL LIBRARIANS TO MEET

The Midwest Regional Group of the Medical Library Association will hold its fall meeting October 19-21 at the Sheraton-Cadillac Hotel in Detroit. Workshops will focus on improved methods and ideas in the field. For further information contact Mrs. Barbara Coe Johnson in Detroit at TE 3-4000, Ext. 396.

Allergy Society Plans Two Meetings

The Michigan Allergy Society will meet at the Pontchartrain Hotel in Detroit at 6:00 p.m., October 18 to hear Mr. J. Shcrayer, Director of Social Work, University Hospital, Ann Arbor, speak on a "Study of Fifty Families of Intractable Asthmatic Children."

Jack E. Goodwin, M.D., Saginaw, program chairman, reports that the annual Members' Night will be held at the Dearborn Inn on January 10.



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MICHIGAN STATE MEDICAL SOCIETY

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MSMS Ballots Due Soon In Judicial Commission Election

MSMS members in three Judicial Commission districts will elect commissioners this month — with December 1 the final date for receipt of the ballots at the MSMS Headquarters.

Ballots, in accordance with the Constitution and Bylaws, were mailed November 11 to the members in the three districts electing this year.

Members will vote in District One for C. Jackson France, M.D., Detroit, or Robert H. Hamburg, M.D., Detroit.

(District is composed of the Wayne County Medical Society.)

Members in District Five will choose from Sherman E. Andrews, M.D., Kalamazoo, or Harold J. Meier, M.D., Coldwater.

(District Five includes the medical societies in the counties of Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Jackson, Kalamazoo, Lenawee, St. Joseph, Van Buren.)

The ballot for District Seven offers members the choice of Reader J. Hubbell, M.D., Traverse City, or W. H. Huron, M.D., Iron Mountain.

(District Seven includes the medical societies of Alpena-Alcona-Presque Isle, Chippewa-Mackinac, Delta-Schoolcraft, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central Counties, Northern Michigan, Ontonagon, Wexford-Missaukee.)

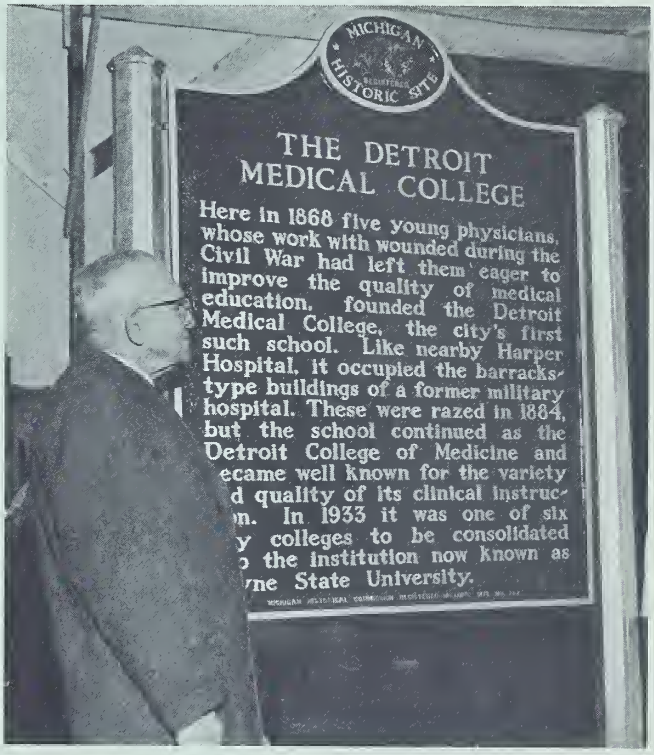
Old Detroit Medical College Marker Erected

An historical plaque, erected November 3 by the Michigan Historical Commission at Woodward and Martin Place, now marks the site where the old Detroit Medical College used to stand, the first college at Wayne State University.

Five physicians, with an initial class of 17, founded the college in 1868. The site is now in the Detroit Medical Center, a multi-million dollar complex of hospitals, clinics, and private offices.

The plaque was unveiled at a special Wayne State University Centennial celebration.

On June 13, 1868, the WSU School of Medicine was chartered. On June 13, 1968, the City of Detroit will salute Wayne State with a civic banquet, involving 100 of Detroit's most distinguished leaders. Honorary chairmen are Governor George Romney and Mayor Jerome P. Cavanagh.


MICHIGAN HISTORIC SITE
THE DETROIT MEDICAL COLLEGE
Here in 1868 five young physicians, whose work with wounded during the Civil War had left them eager to improve the quality of medical education, founded the Detroit Medical College, the city's first such school. Like nearby Harper Hospital, it occupied the barracks-type buildings of a former military hospital. These were razed in 1884, but the school continued as the Detroit College of Medicine and ecame well known for the variety d quality of its clinical instruc n. In 1933 it was one of six y colleges to be consolidated the institution now known as ne State University.

Henry R. Carstens, M.D., of Birmingham, past president of MSMS and a graduate of Wayne State's Medical School in 1911, was one of the special guests at the plaque unveiling ceremony because his life is closley involved with the old Detroit Medical College. His father, J. H. Carstens, M.D., was the first student to enroll in the college.

over
200
medical careers•one may be just right for you!
• MICHIGAN STATE MEDICAL SOCIETY
• MICHIGAN HEALTH COUNCIL
WRITE . . . BOX 431
EAST LANSING

100 Health Career Billboards Go Up across Michigan

BY PETER HOHEISEL
OF THE MSMS STAFF

Throughout October and November workmen have been busy pasting 100 posters on Michigan billboards with the message: "Over 200 Health Careers – One may be just right for you."

Initiated during Community Health Week and sponsored by the Michigan State Medical Society and the Michigan Health Council, the seven-color posters were obtained from the AMA in an effort to encourage the young people of Michigan to see the wide career possibilities in the field of medicine.

The State Outdoor Advertising Council was extremely helpful in getting this message to the public.

A comment was received from the Calhoun County Health Careers Council after four posters went up in that county: "It's a striking ad which has been well placed in our city. They contributed greatly to our observance of Community Health Week."

The billboard project was recommended by the MSMS Public Relations Committee, Brock E. Brush, M.D., Chairman.

Rheumatic Fever Conference at MSU

The Rheumatic Fever Conference at MSU Kellogg Center November 8 was attended by about 200 persons. Featured speaker was Alvan R. Feinstein of the Yale University School of Medicine, on "Current Concepts in Rheumatic Fever and Rheumatic Heart Disease Control."

Hayes Begins At Blue Shield

Since October 1, Louis F. Hayes, M.D., has been working part time with Blue Shield in Detroit at the newly created post of vice-president for medical affairs.

At the same time, Doctor Hayes, a Gaylord general practitioner since 1957, has been arranging for the transfer of his patients to other physicians in the Gaylord area in preparation for his assuming full time Blue Shield responsibilities, January 1.

Doctor Hayes, who has served on the Blue Shield Board of Directors since 1962 is a former vice-speaker of the MSMS House of Delegates.

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Send news and photographs for the big journal issue of *Michigan Medicine* and for the *News Extra* to: Herbert A. Auer, Managing Editor, *Michigan Medicine,* Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.

ADD: IN MEMORIAM

In addition to the names reported in the November "In Memoriam" the following news has reached the MSMS office. Details will follow in the December issue of Michigan Medicine.

Gilbert Wilfred Benson, M.D., 64, Escanaba, died October 4.

Albert J. Boyle, M.D., 57, Detroit, died September 12.

Howard O. Brush, M.D., 75, Port Huron, died October 5.

James G. Garr, M.D., 75, Detroit, died October 29.

Thomas F. Clifford, M.D., 79, Owosso, died October 2.

Thomas S. Davies, M.D., 84, Detroit, died November 6.

Clifford T. Ekelund, M.D., 74, Pontiac, died October 22.

Benjamin L. Franklin, M.D., 89, Remus, died October 16.

Homer L. Johnson, M.D., 68, Southfield, died October 20.

Vahram Kasabach, M.D., 58, Detroit, died October 10.

John A. Maurer, M.D., 64, Saginaw, died August 30.

Ira D. McCoy, M.D., 78, Port Austin, died September 25.

Health Careers-Institute Set Dec. 4-6, Battle Creek

A three-day Institute on Health Careers, sponsored by the Michigan Health Council, the Michigan Personnel and Guidance Association and Western Michigan University, will be held December 4-6 at the M.E.A. Conference Center near Battle Creek.

The first day will focus on how counselors and vocational education directors can work more effectively with students.

The second day and third morning will be of interest to members of the health professions and auxiliaries who are interested in developing health manpower programs.

For reservations write the M.E.A. Conference Center, P.O. Box 79, Battle Creek, Mich. 49016.

For further program information contact the Michigan Health Council, P.O. Box 431, East Lansing, 48823. Tel: 337-1615.

Elks Honor Stapleton

The Detroit Lodge of Elks, at their annual old-timer's night on October 26 honored William J. Stapleton, M.D., and other long-time members of the Elks.

Doctor Stapleton, who is 91 years old, is a member of the Scottish Rite of Masons in the Valley of Detroit and has been an Elk for 65 years.

SYMPOSIA ON TRAUMA DEC. 6-7, DETROIT

The 15th Annual Symposium on Trauma, at the Wayne County Medical Society headquarters in Detroit, December 6 and 7, will involve several outstate experts.

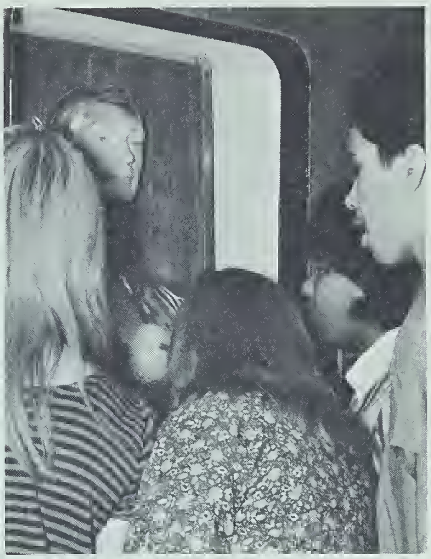
Theodore Drapanas, M.D., professor of surgery at the University of Pittsburgh, will take part in a panel on "Organ Failure in Trauma."

"Burns" will be the topic handled by Col. John Moncrief, M.D., Department of Surgery, Brooke Army hospital, San Antonio, John Boswick, M.D., Dept. of Surgery, Northwestern University and Cook County hospital, Chicago, and John Davis, M.D., Dept. of Surgery, Western Reserve University, Cleveland.

On December 6 there will be an evening banquet at the Statler Hotel at 7:00 PM.

The luncheon speaker, December 7, will be Franklin Wade, M.D., who will discuss "Experiences in Vietnam."

Physicians may obtain a copy of the detailed program from Chairman Joseph L. Posch, M.D., 1408 Kales Bldg., Detroit 26. Tel: WO 2-1066.



Careers Mobile All November In Detroit

During the entire month of November, thousands of Detroit Public school students will visit the Health Careers Mobile to learn about Michigan medical history and the many career possibilities open to them.

Visits by the students are highly organized so they pass through the trailer in small groups in order to make the visit of maximum service to the student. A guidance counselor is on hand to answer questions. Each student is given a card so he can obtain more health career information if he desires.

In the early part of November the MHC-MSMS Health Careers Mobile was at Earhart Junior High School and at Webber Junior High. November 13-17 it will be at Kettering High School, 6104 Van Dyke; Nov. 20-23 at Sherrard Junior High, 8300 Cameron; Nov. 27-Dec. 1 at Foch Junior High.

The unit is open on Mondays from 11:00 AM to 5:00 PM. Tuesday through Friday it is open from 8:00 AM to 5:00 PM. Further information can be obtained by calling any of these schools and asking for the Health Careers Mobile Site Coordinator.

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The following material may be useful to you. Check any item
sired, cut out the form, and mail it in an envelope to: Michigan
ate Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.

______ **The American Medical Association's Archive-Library — Pamphlet describing the facilities and services of the AMA library.**

______ **Horizons Unlimited — Handbook describing rewarding career opportunities in medicine and allied fields.**

______ **Medicines and Your Family's Health — Reprint of an article from November 1967 issue of Reader's Digest.**

______ **What Makes Sammy Smoke? — Brochure by the Michigan Cancer Foundation attempting to point out why children begin to smoke and what parents can do to prevent it.**

(Your address already is on the back of this coupon)

AMEF Plans Party to Aid Med Students

Members of the African Medical Education Fund have completed arrangements for the organization's principal fund-raising activity of the year — a Thanksgiving eve cabaret party to be held at the Latin Quarter.

Officers of the group point out that "the ultimate solution to the staggering medical problems of Africa must lie in the hands of Africans." The AMEF is contributing to the fulfillment of the need for qualified African doctors by giving financial assistance to medical students from several African nations.

During the seven years of its existence, the Fund has assisted fifteen students, four of whom have now graduated. This year nine students have received a total of $4,750.

Officers of the Fund are: Charles H. Wright, M.D., President; Carl C. Beckwith, M.D., Vice-President; Ethelene Crockett, M.D., Secretary; Robyn Arrington, M.D., Treasurer. The Chairman of the Scholarship Committee is Charles Whitten, M.D.

The MSMS citation, authorized by the House of Delegates, commemorating the Sesquicentennial of the University of Michigan was presented at the recent U-M Medical Center Reunion by MSMS President B. M. Harris, M.D., at right. The handsome citation was accepted by George W. Slagle, M.D., left, Battle Creek, president of the U-M Medical Center Alumni, and Harry A. Towsley, M.D., center, who represented the dean.

Hear Reed, Wilson At Cancer Symposium

The Darling Memorial Center and the Michigan Cancer Coordinating Committee presented a Symposium on Cancer recently at the Wayne County Medical Society building in Detroit.

About 50 physicians heard talks by Melvin L. Reed, M.D., assistant clinical director of the Darling Memorial Cancer Center at Grace Hospital, on "Newer Forms of Practical Cancer Chemotherapy," and by Gerald S. Wilson, M.D., attending surgeon at Grace Hospital, on "Cathteric Artery and Cauterization Techniques and Complications."

Charles P. Hall, Jr., right, receives the award for the most scholarly contribution to the literature of medical economics for the year ending June 30, 1967, from the National Association of Blue Shield Plans at the national Blues meeting recently in Washington, D.C. Professor Hall, of Temple University, wrote the winning article "The Future of Health Insurance, Prepayment and Medicine" for the MSMS Committee on Medical Socio-Economics and it appeared in the January issue of **Michigan Medicine.** The award was made by Carl R. Ackerman, M.D., left, Chairman, National Blue Shield Board of Directors.

MDPAC OFFERS DUES OPTION

An additional MDPAC and AMPAC billing, payment of which is optional, will be included in the 1968 dues statement to MSMS members.

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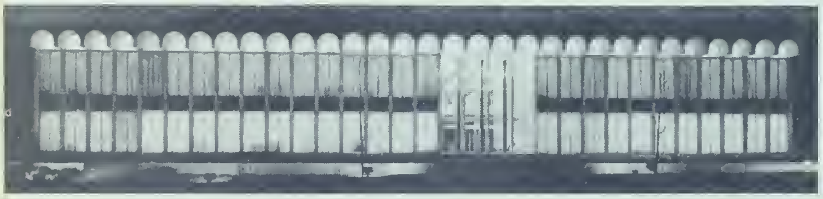

MICHIGAN MEDICINE

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Health Careers Mobile To Get New Exhibits

The week-long tour of the Health Careers Mobile which began on December 10 at Albion Community Hospital is the last trip before the unit moves back to East Lansing for some remodeling.

During the latter part of December and the month of January some new exhibits will be added to the trailer.

The Health Careers Mobile is expected to be on the road again some time in February.

AMA Delegates Adopt Resolutions Offered by MSMS

Two Michigan resolutions were passed by the AMA House of Delegates at its November 26-30 meeting in Houston.

Passed by acclamation was a resolution extending "congratulations to Wayne State University and its School of Medicine for 100 years of devoted service to the people of the great State of Michigan."

Also passed by the AMA House of Delegates was a resolution calling upon "the Governors of each State to avail themselves to the fullest possible extent of the expertise of health professionals in the implementation of their Comprehensive Health Planning Program."

A MSMS resolution which did not pass asked the AMA to "establish a central source for all resolutions adopted by constituent state medical society houses of delegates."

Michigan physicians who were present as **Delegates** were: Luther R. Leader, M.D., Chairman, Otto K. Engelke, M.D., John R. Heidenreich, M.D., Robert E. Rice, M.D., Sidney Adler, M.D., George W. Slagle, M.D., Donald N. Sweeny, Jr., M.D.

Alternate Delegates were: Bradley M. Harris, M.D., Gilbert B. Saltonstall, M.D., John J. Coury, M.D., Marjorie P. Meyers, M.D., Vernon V. Bass, M.D., Harold A. Furlong, M.D.

Also present were Section Delegates Kenneth Mathews, M.D., (Allergy) and Harold F. Falls, M.D., (Opthalmology).

Hamburger, Huron, Andrews Elected To Judicial Body

In two-way contests for three seats on the MSMS Judicial Commission, the recent election resulted in the selection of Robert H. Hamburger, M.D., Detroit; W. H. Huron, M.D., Iron Mountain, and Sherman E. Andrews, M.D., Kalamazoo.

Doctors Hamburger and Huron will be new on the 10-member Judicial Commission, while Doctor Andrews will begin a second term.

The Judicial Commission, according to the MSMS Constitution, "shall be the body having general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members and professional conduct generally."

The Bylaws divides the state into districts and only MSMS members in those districts vote for their representative.

Doctor Hamburger will represent District I, which is Wayne County.

Doctor Huron will represent District VII, which includes the following county societies: Alpena - Alcona - Presque Isle, Chippewa - Mackinac, Delta - Schoolcraft, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central Counties (Crawford, Gladwin, Kalkaska, Montmorency, Ogemaw, Oscoda, Otsego, Roscommon), Northern Michigan (Antrim, Charlevoix, Cheboygan, Emmet), Ontonagon, Wexford-Missaukee.

Doctor Andrews was elected by the members of District V, which includes Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Jackson, Kalamazoo, Lenawee, St. Joseph, Van Buren.

D. N. Sweeny, Jr., M.D., Detroit, is Chairman of the Judicial Commission; H. A. Furlong, M.D., Pontiac, Vice-Chairman.

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The MSMS Cancer Committee efforts to conduct a pap smear educational campaign among Michigan women were advanced at a recent meeting of the committee at the MSMS headquarters. During the discussion, Vainutis Vaitkevicius, M.D., Detroit, explained a graph illustrating the number and kinds of cervical cancer found during 1953-1967 to three of the committee members, left to right, Max E. Dodds, M.D., Flint, Committee Chairman; Oscar D. Stryker, M.D., Mt. Clemens, Chairman of the MSMS Public Health Committee, and John A. Cowan, M.D., Chief of the Division of Adult Health, Michigan Department of Public Health.

A Christmas Message From President Harris:

When I accepted the presidency of the society, I knew I could confidently rely on MSMS physicians and staff members for advice and help in the many activities in which MSMS is engaged. It is one thing to be confident that the help will be forthcoming; another to actually experience it.

By this time, however, I have experienced the support and fraternity of MSMS members in a new way because of my new responsibilities as president. Now, at Christmas I would simply like to express my deep gratitude for the encouragement and support I have received from countless MSMS members around the state. Because of it I look forward to the new year.

When I am questioned by various leaders and news people around the state about "What does the medical profession feel on such and such an issue" my job is not to give my own opinion but to reflect as accurately and as comprehensively as possible the views of MSMS members. To do this well means a great deal of discussion about the many issues facing the medical profession today.

I can serve you well as president only insofar as I know your feelings and thoughts on the many problems we face.

At this time, therefore, I would like to personally thank each MSMS member for the letters, conversations, and other communications which have helped me during the past three months.

I would like you to feel free to write or phone me at any time during the year about any matters which are of concern to you as a practicing physician.

May you and your families have a joyful Christmas and a happy New Year.

MSMS President Bradley M. Harris, MD

TB Seal Sale Seeks $1,600,000

An attractive Christmas train on the 1967 TB seals signals the annual campaign against tuberculosis and other respiratory diseases.

The Michigan Tuberculosis and Respiratory Disease Association reports that last year Christmas seals brought a total of $1,500,000 in Michigan. The goal for this year's campaign is a state-wide total of $1,600,000.

The money is used to provide breathing exercise courses for asthmatic children, smoking education in schools and smoking withdrawal clinics, tuberculin skin testing and chest X-ray programs.

A share of the contributions also goes into research being conducted at many of Michigan's major universities.

ADD: IN MEMORIAM

In addition to the names reported in the December "In Memoriam" the following news has reached the MSMS office. Details will follow in the January issue of *Michigan Medicine*.

Lawrence R. Atler, M.D., 68, Detroit, died November 14.

Oliver W. Lohr, M.D., 73, Saginaw, died October 25.

Edgar C. Sites, M.D., 75, Port Huron, died November 7.

Carl G. Wencke, 78, M.D., Battle Creek, died November 11.

Doncald R. Wright, M.D., 72, Flint, died November 17.

Offer Rehabilitation Seminar for Nurses

Frank H. Krusen, M.D., Philadelphia, authority on rehabilitation, will participate in the all-day seminars January 17-18, sponsored for nurses by the Kenny-Michigan Rehabilitation Foundation at Mercy College Student Center, Detroit.

Extract, Nov. 8 Meeting of the MSMS Council:

The Council received a report of an informational meeting, authorized by The Council, for the purpose of informing interested chairmen of MSMS committees regarding the plans of the Michigan Association of Regional Medical Plans.

The Council received a request to publish the "Hospital Utilization Review Manual" and replied that MSMS had no proprietary or copyright interest in the "Hospital Utilization Review Manual" and that the University of Michigan Post-graduate Education Department may do as it wishes with it.

THE COUNCIL RECEIVED correspondence from the MSMS Section on Public Health and Preventive Medicine opposing the proposed merger of the State Department of Public Health with the State Department of Social Services.

The Council approved a program grant of $500 to contribute to the success of the 1968 Student American Medical Association annual meeting to be held in Detroit, in April, 1968.

The Council was informed of the resignation of Carl B. Beeman, MD, Grand Rapids, as a member of the Judicial Commission. President Harris, according to the By-laws, is authorized to appoint a successor for the interim and announced, after discussion, that he would do so at the December meeting.

The Finance Committee reviewed in detail the proposed budget for 1967-68 making many modifications and amendments and agreed to recommend a final budget to The Council for its approval in December.

The Council approved the Finance Committee recommendation that a three-member committee of The Council be appointed with Clyde Hardwick, as advisor, to work with the Executive Director in planning and initiating the legal steps necessary for establishment and initial operations of the Health Information Research Institute. Finance Committee also authorized a budget of $5,000 for this purpose.

THE FINANCE COMMITTEE also recommended, and The Council approved, a request from the Michigan Health Council for a 1967-68 grant to continue the Health Careers Mobile.

The Council reviewed the minutes of the Committees on Professional Insurance Plans, Highway Injury, Michigan Medical History and the Standing Committees of The Council.

Luther R. Leader, MD, Chairman of the Michigan Delegation to the American Medical Association, presented a detailed report of the actions of the Michigan delegation and the actions of the AMA House of Delegates meeting in Houston in November.

Michigan Medical Service Board Chairman, John M. Wellman, MD, reported to The Council on 1) preparation for the transition of existing Blue Shield general coverage to the new program hitherto discussed with The Council; 2) attention to negotiations between the automobile manufacturers and labor in regard to new hospital, surgical, medical and drug benefits; 3) completion of an educational and promotional campaign intended to increase informal doctor participation; 4) continuation of progress toward erection of a new Detroit Blue Shield-Blue Cross building.

THE COUNCIL RECEIVED a progress report of the treasurer regarding the proposed plan for asset management which was then approved in principle by the House of Delegates and agreed that additional information was needed before The Council could further discuss the matter.

WSU Blood Seminar Lists 22 Papers

Wayne State University's Sixteenth Annual Symposium on Blood, sponsored by the School of Medicine Department of Physiology and Pharmacology, will be held on January 19 and 20. "Fibrin, Fibrinolysis, and Blood Coagulation" will be the theme explored by scientists from universities, laboratories, and hospitals all over the United States, as well as from Canada, the Netherlands, and Germany.

Kenneth Johnson, MD, MSMS secretary discusses organized medicine with MSU medical students at the MSMS Headquarters. The students are, from left to right, Anne Maledon, Samuel Oberstein, Leonard Dorey, Howard Feldman, Larry Eidt. MSMS hosted the meeting to explain the state society's purposes and activities.

Towsley Now Heads Health Council; Upjohn Named President-Elect; Two Join Hall of Fame

The recent annual meeting of the Michigan Health Council saw Harry A. Towsley, M.D., Ann Arbor, installed as president; and E. Gifford Upjohn, M.D., Kalamazoo, selected as president-elect.

Doctor Towsley is Chairman of the Department of Postgraduate Medicine at the University of Michigan Medical School, and Doctor Upjohn is Chairman of the Board of the Upjohn Company.

At the Silver Anniversary Luncheon of the Health Council, December 5, Doctor Upjohn was inducted into the Health Hall of Fame. Doctor Towsley, in presenting this award, noted that it had been made "in recognition of his world-wide achievements in the medical and pharmaceutical fields and for his long-time interest and efforts that have made his home city, his home state and the entire United States a healthier and happier place in which to live."

EMORY W. MORRIS, D.D.S., Battle Creek, also was inducted with Doctor Upjohn into the Hall of Fame in Health. Doctor Morris was honored "in recognition of his magnificent performance as President and General Director of the W. K. Kellogg Foundation that has resulted in more than one hundred fifty million dollars being judiciously expended to advance the well-being of people throughout the United States, Canada, Latin America, Europe and Australia."

Nearly a hundred of Michigan's leading guidance counselors, directors of health occupational education and nursing education were guests at the First Annual Michigan Institute on Health Careers to acquaint them with the great need for students to enter health careers.

The world premiere of a new AMA film, "Horizons Unlimited," was a main feature at the Institute. The 27-minute health careers film will be released nationally during 1968.

Featured speakers during the three-day meeting were Owen Pinkerman, Royal Oak, Vice-President, Wm. A. Beaumont Hospital; Malcolm Phelps, M.D., El Reno, Oklahoma, Vice-President of the American Medical Association and former director of the Voluntary Physicians for Vietnam Program; and Kenneth Skaggs, Washington, D.C., Director, Health Occupations Project, American Association of Junior Colleges.

THE HEALTH CAREERS Council of Calhoun County, the Belmont Health Council of Rockford, and the Battle Creek *Enquirer and News* were honored by the Michigan Health Council for their efforts in promoting health career activities, improved health programs for a rural community and health news.

OTHER OFFICERS and trustees re-elected to serve with Doctors Towsley and Upjohn include Hugh W. Brenneman, MSMS executive director, Secretary; Russell A. Fairles, East Lansing, Senior Vice-President, Michigan National Bank, Treasurer; J. Kenneth Altland, M.D., Lansing, Director, Medical Services, Michigan Department of Social Services, Medical Advisor; Lester P. Dodd, Detroit, Legal Advisor; and John A. Doherty, Executive Director, Michigan Health Council, Assistant Treasurer.

Newly-elected trustees are Winston Schuler, Marshall, President of Win Schulers, Inc.; and Donald Bunting, East Lansing, General Manager, Sears-Roebuck Company of Lansing.

Huron Joins State Registration Board

William D. Huron, M.D., one of the six physicians to receive a MSMS Certificate of Commendation at the 1967 Annual Session, has been appointed to the State Board of Registration in Medicine for a four-year term ending September 30, 1971.

Governor George Romney named Doctor Huron to succeed Frederick Sabin, M.D., who recently was named to the Northern Michigan University Board of Control.

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